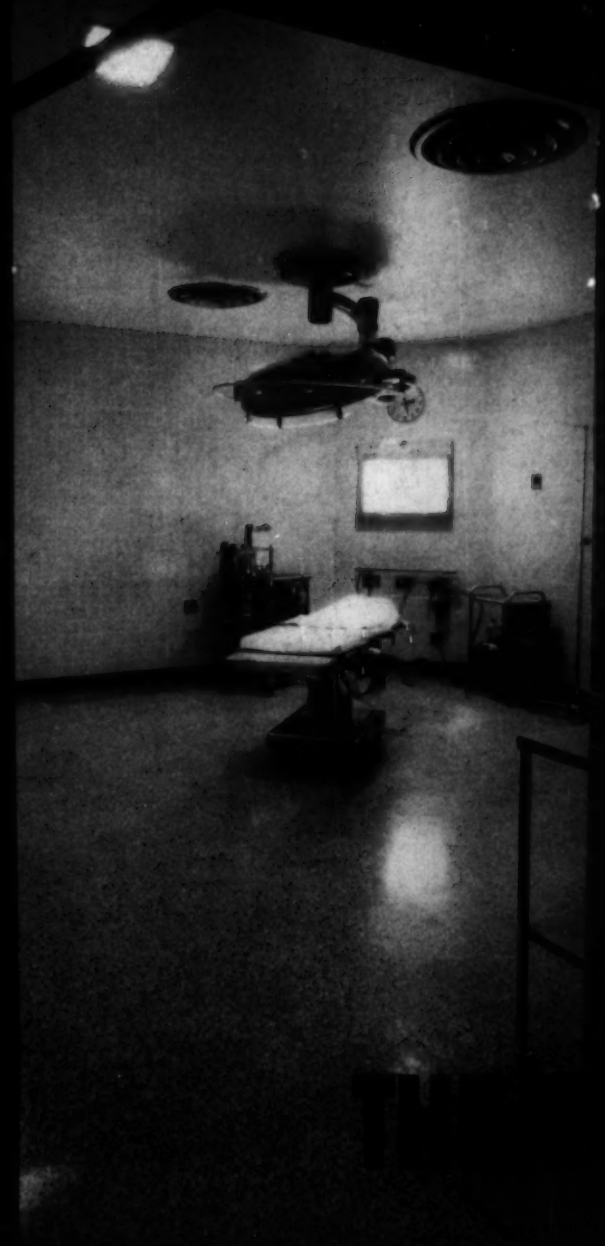
62ND ANNUAL MEETING • SAN FRANCISCO • AUG. 29-SEPT. 1

HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

MARCH 16, 1960



PLANNING
AND CONSTRUCTION
ISSUE

ICAL SUITE

Modern Fairview Park Hospital, Cleveland, uses HAUSTED Easy Lift wheel stretchers exclusively in their Recovery Room and Emergency Room. Mr. V. D. Seifert, Administrator, tells why in his letter.

Fairview Park Hospital
18101 Lorain Avenue
Cleveland 11, Ohio

Office of the Administrator

Clearwater 2-1222

Fairview Park Hospital formerly used beds in the Recovery Room. We now use Hausted Easy Lift slide and tilt stretchers exclusively for several reasons. First is their easy maneuverability - no longer do we scratch and mar corridor walls and door jambs. The added safety of the large, conductive casters is important, too. Also the convenience of the many useful accessories appeals to us. We now can accommodate more patients in the Recovery Room without crowding.

Administrator

For complete information on HAUSTED hospital equipment, write

The mark of quality and leadership in hospital equipment

SIMMONS COMPANY
HAUSTED DIVISION
MEDINA, OHIO

New Baptist Memorial Hospital, Oklahoma City. Completely air-conditioned with Gas-operated Carrier Absorption Refrigeration. Architect and Consulting Engineer: Coston, Frankfurt and Short. General Contractor: G. E. Bass & Company, Inc. Mechanical Contractor: Wattie Wolfe Company. All of Oklahoma City.

This new hospital controls air conditioning costs with GAS-operated CARRIER absorption refrigeration.

The beautiful new Baptist Memorial Hospital in Oklahoma City combines advanced facilities with advanced equipment that won't price itself out of service. For modern air conditioning they chose one of the most efficient systems available... Gas-operated Carrier Absorption Refrigeration.

The Carrier absorption unit's energy source is low pressure steam, from the same gas-fired boilers that heat the hospital in winter. The unit converts this steam into chilled water for cooling air.

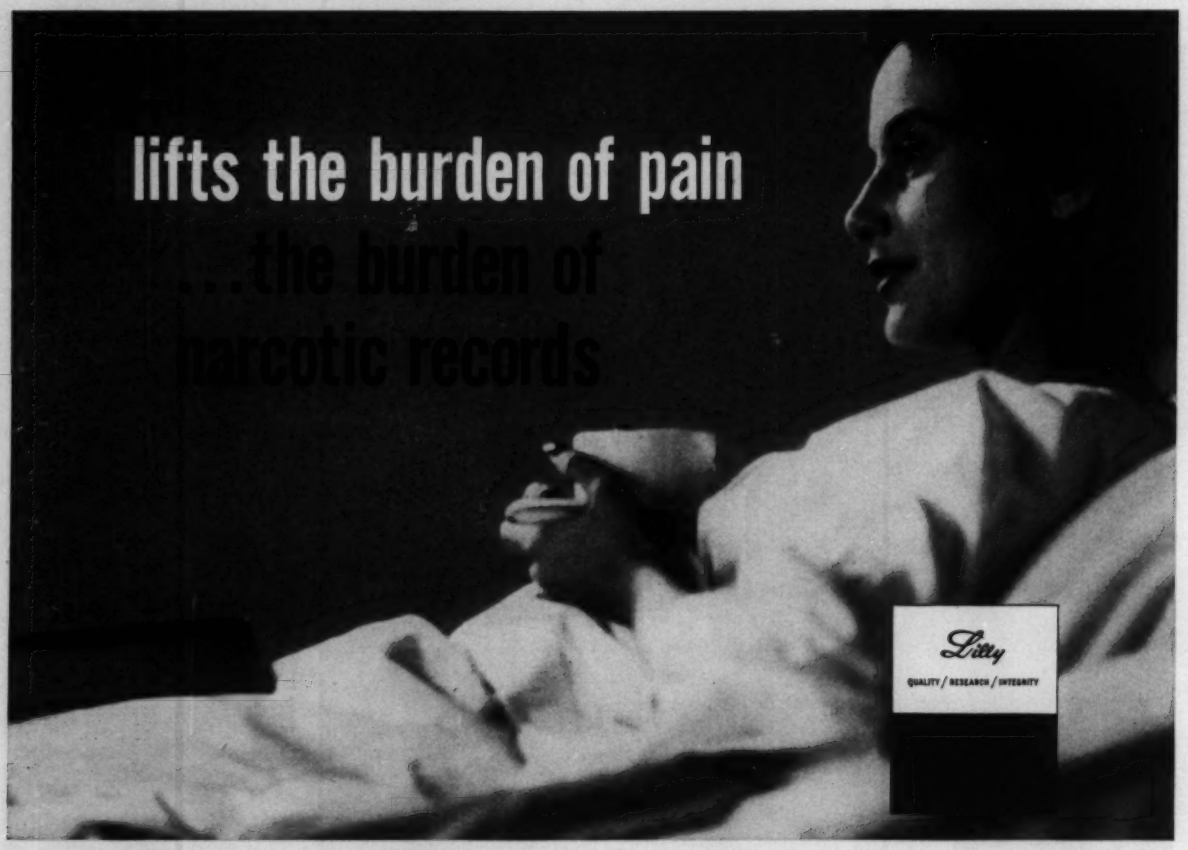
Thus, boiler capacity is put to efficient year 'round use...heating in winter...cooling in summer... and supplying steam for sterilizers, laundry and other hospital needs.

Carrier absorption units operate without noise or vibration. There are no major moving parts to maintain or repair. And thrifty gas keeps fuel costs low.

Control *your* air conditioning costs with Gas-operated Carrier Absorption Refrigeration. For full details call your local gas company, or write to Carrier Corporation, Syracuse 1, New York. **AMERICAN GAS ASSOCIATION.**

This Carrier Automatic Absorption Refrigeration unit provides 530 tons of cooling from a central location in the hospital. Two gas-fired boilers supply all the steam used for heating and absorption cooling.

FOR HEATING & COOLING GAS IS GOOD BUSINESS!



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The clinical usefulness of Darvon® (dextro propoxyphene hydrochloride, Lilly), alone and in combination, has been confirmed by more than a hundred investigators in the treatment of over 6,300 patients. Under study were patients from every branch of medicine, including obstetrics, gynecology, surgery, orthopedics, and oncology.

Consolidation of these reports shows that 5,663 patients (89.9 percent) obtained effective analgesia. The remaining 637 patients (10.1 percent) were not benefited.

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Darvon	32	mg. (approx. 1/2 gr.)
Acetophenetidin	162	mg. (2 1/2 grs.)
A.S.A.® (acetylsalicylic acid, Lilly)	227	mg. (3 1/2 grs.)
Caffeine	32.4	mg. (1/2 gr.)

Usual dosage: 1 or 2 Pulvules three or four times daily.

Also available: Darvon, in 32 and 65-mg. Pulvules.

Usual dosage: 32 mg. every four hours or 65 mg. every six hours.

Darvon® Compound (dextro propoxyphene and acetylsalicylic acid compound, Lilly)

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HOSPITALS

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special issue on planning and construction

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cover

The development and latest trends in surgical suite design are the theme of this special issue on hospital planning and construction. Among the outstanding examples of surgery design included in this issue is the operating room on the cover, a feature of the new Lutheran General Hospital of Park Ridge, Ill. This suite is described in an article beginning on page 74. Cover photo by Robert McCullough. (Other picture credits on page 170.)

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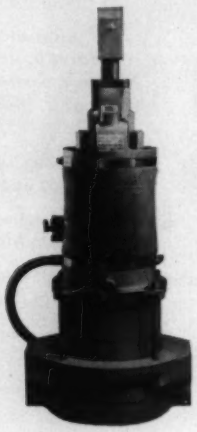
SEALED POWER



American's exclusive Sealed Power Unit is a unique combination of air and hydraulics that makes the Dyna-Pak the fastest, smoothest operating laundry press on the market today!

Here's why:

Sealed Power guarantees high, uniform pressure, without adjustments

Power Unit automatically compensates for varying thicknesses of garments and padding, exerts the same high ironing pressure on every single piece of work. *No pressure adjustments are ever necessary!*

Sealed Power means fast, smooth head action

In head closing, fast initial movement, smooth snubbing and full pressure are combined in one *continuous* sequence. The return of head from pressure through snubbing to full open is also a fast, uninterrupted movement. Simple needle-valve adjustment, in integral hydraulic snubber, assures smooth snubbing for both opening and closing head.

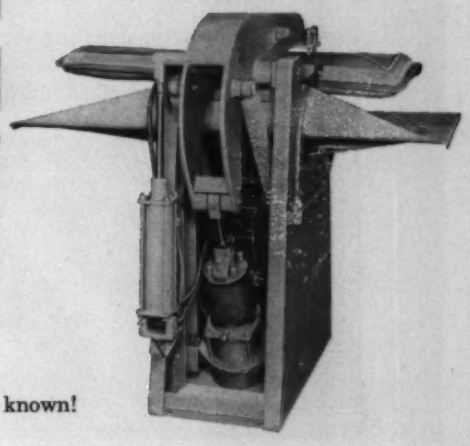
Sealed Power Unit is self-contained, leak-proof

The hydraulic cylinder in the Power Unit is *completely sealed*. Absence of *external* high-pressure hydraulic connections eliminates costly, troublesome oil leaks and prevents contamination of hydraulic fluid by dust or lint.

ONLY DYNA★PAK

has

SIMPLE DESIGN



Unusual simplicity of design makes the Dyna-Pak the fastest, most efficient, easiest-to-operate and easiest-to-maintain laundry press the industry has ever known!

Here's why:

Simple Design means fewer working parts, easy accessibility

Fewer parts mean fewer things to lubricate, adjust or replace, and the new Dyna-Pak has up to 400 fewer parts than any other laundry press now on the market. Sealed Power eliminates toggles, cams, levers and pivots. The only mechanical operating parts are the Yoke, Head-Closing Cylinder and Sealed Power Unit.

Controls, valves and lubricating points are all readily accessible, and there are only nine lubricating points (7 grease, 2 oil) on the entire Press. The simple air circuit is easily followed for checking air lines and connections.

Simple Design includes unique "Floating" Head

A universal ball-joint mounting causes ironing head to automatically adjust itself to compensate for different thicknesses of garments and varying conditions of padding on the buck. The "floating" head applies uniform high pressure over the entire surface of each garment to produce an exceptionally fine-quality finish.

Simple Design incorporates Sliding-Type Master Control Valve

Mounted right on the front of the Sealed Power Unit to control admission of air to the Pneumatic Cylinder, the Master Control Valve has no discs, seats or holders to replace or adjust and is not critical to wear, shock or deterioration.

American's new Dyna-Pak Press is available in a wide range of models for finishing all types of laundered apparel including shirts, coats, pants, gowns and uniforms. Dyna-Pak Presses can also be furnished in various combinations of models to form job-balanced, high-production units for any specific requirements.

See for yourself why the revolutionary new Dyna-Pak, featuring Sealed Power and Simple Design, is the most exciting laundry press development in years! Have your nearby American representative arrange a demonstration soon, or mail the coupon for Dyna-Pak Catalog.

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hospital association meetings

AMERICAN HOSPITAL ASSOCIATION

NATIONAL MEETINGS

1960

Aug. 29-Sept. 1—**62nd annual meeting,** San Francisco (Civic Auditorium and Jack Tar Hotel)

MEETING AND INSTITUTE

CALENDAR

THROUGH AUGUST 1960

(American Hospital Association Institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. ***Other organizations in the health field are shown in ITALICS.)***

MARCH

21-24 ***American Academy of General Practice,*** 12th Annual Scientific Assembly, Philadelphia (Convention Hall)

21-25 **Dietary-Housekeeping-Nursing Departments Relationships,** Chicago (AHA Headquarters)

22-24 Kentucky Hospital Association, Louisville (Kentucky Hotel)

24-26 Louisiana Hospital Association, Baton Rouge (Bellemont Motor Hotel)

28-30 New England Hospital Assembly, Boston (Hotel Statler)

31-April 1 Georgia Hospital Association, Jekyll Island (Wanderer Motel)

APRIL

3-7 ***Annual Conference of Blue Cross Plans,*** Los Angeles (Statler Hotel)

4-6 **Administrators' Secretaries,** Dallas (Adolphus Hotel)

4-6 **Hospital Organization,** Chicago (AHA Headquarters)

4-7 Ohio Hospital Association, Columbus (Veterans Memorial Auditorium)

4-8 ***American College of Physicians,*** San Francisco (Mark Hopkins and Fairmont)

4-8 **Nursing Service Administration,** Omaha (Hotel Paxton)

11-14 **Hospital Engineering,** Minneapolis (Radisson Hotel)

18-19 **Insurance for Hospitals,** Atlanta (Henry Grady Hotel)

21-22 Carolinas-Virginias Hospital Conference, Roanoke (Hotel Roanoke)

25-28 Association of Western Hospitals, Los Angeles (Statler Hotel)

27-29 Middle Atlantic Hospital Assembly, Atlantic City (Convention Hall)

27-29 Midwest Hospital Association, Kansas City (Municipal Auditorium)

28-29 Iowa Hospital Association, Cedar Rapids (Hotel Roosevelt)

MAY

2-4 Tri-State Hospital Assembly, Chicago (Palmer House)

2-6 ***American Nurses' Association,*** Miami Beach (Miami Beach Hall)

2-11 ***Pan American Medical Association,*** 35th Anniversary Congress, Mexico City (National Auditorium)

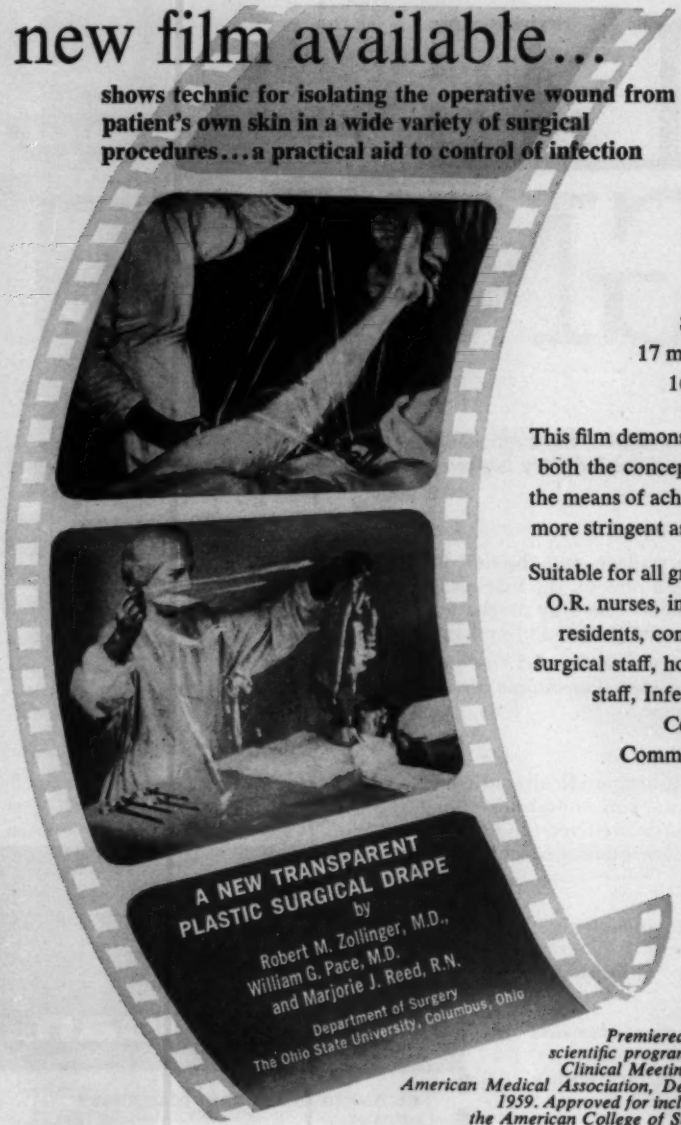
3-6 **Occupational Therapists,** Chicago (AHA Headquarters)

3-6 Southeastern Hospital Conference, Miami Beach (Deauville Hotel)

(Continued on page 8)

new film available...

shows technic for isolating the operative wound from the patient's own skin in a wide variety of surgical procedures...a practical aid to control of infection



Color
Sound
17 minutes
16 mm.

This film demonstrates both the concept and the means of achieving more stringent asepsis.

Suitable for all groups: O.R. nurses, interns, residents, complete surgical staff, hospital staff, Infections Control Committees.

Premiered on the scientific program of the Clinical Meeting of the American Medical Association, December, 1959. Approved for inclusion on the American College of Surgeons' list of approved films.

To schedule a showing, send requests to the Aeroplast Corporation, Station A—Box 1, Dayton 3, Ohio. Please mention a preferred and an alternate date. Would you also like to show a 16 mm., color and sound, film on the use of spray-on plastic surgical dressing? This is available for showing with the above film, or separately, if you prefer.

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Now . . . all MATEX surgeons' gloves are made of a new compound that produces **much softer** and **more comfortable** gloves. Because they are more pliant, they do not bind or constrict free movement of hands and fingers. Thus, they dramatically **lessen hand fatigue.**

Mechanical tests prove new MATEX gloves are up to 50% softer than average gloves. And they provide the bare-finger tactility for which MATEX gloves have always been famous.

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Massillon, Ohio

4-6 New Mexico Hospital Association, Albuquerque (Western Skies Hotel)

5-7 ***Association of University Programs in Hospital Administration,*** Williamsburg, Va., (Williamsburg Inn)

9-13 ***American Psychiatric Association,*** Atlantic City (Convention Hall)

10-12 Texas Hospital Association, Dallas (Memorial Auditorium)

11-13 Upper Midwest Hospital Conference, Minneapolis (Auditorium)

12 Massachusetts Hospital Association, Boston (Hotel Statler-Hilton)

16-18 ***American National Red Cross,*** Kansas City

16-18 **Hospital Law,** Washington, D.C. (Willard Hotel)

16-18 **Patterns and Principles for Auxiliary Leaders,** Chicago (AHA Headquarters)

16-19 **Hospital Dental Service,** Atlanta (Henry Grady Hotel)

23-26 **Evening & Night Nursing Service Administration,** Seattle (New Washington Hotel)

23-27 **Dietary Department Administration,** Washington, D.C. (Willard Hotel)

26-27 Tennessee Hospital Association, Memphis (Peabody Hotel)

30-June 2 Catholic Hospital Association, Milwaukee (Auditorium)

new style **POST-OPERATIVE STRETCHER** *with* **DUAL CRANK CONTROL by** J&J

one crank positions the litter
another crank positions the back rest

Versatility makes this stretcher most useful and convenient

Handle mechanism is color-coded for quick identification of desired position.

SEE IT AT THE N. E. HOSPITAL ASSN. SHOW BOOTHS 32-33

1. The 3-position litter crank makes it possible to raise or lower the litter to the desired position in seconds. This one crank elevates *either end.*
2. The back rest crank permits Fowler positioning. The back support is securely geared to stay rigid in any position between flat and maximum elevations. The crank is hinged and spring-loaded and is not in the way when not in use.
3. Practically the same back support, designed for manual operation, can be provided for the foot end of the stretcher to permit leg elevation.

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JUNE

6-10 **Food Purchasing,** Chicago (AHA Headquarters)

7-8 Maine Hospital Association, Rockland (Samoset Hotel)

8-10 North Carolina Hospital Association, Fort Bragg

11-16 ***American Society of X-Ray Technicians,*** Cincinnati (Netherland Hilton Hotel)

13-15 **Advanced Personnel Administration,** Chicago (AHA Headquarters)

13-17 ***American Medical Association,*** Miami Beach (Miami Beach Hall)

19-21 Michigan Hospital Association, Traverse City (Park Place Hotel)

19-24 ***American Society of Medical Technologists,*** Atlantic City (Hotel Ambassador)

20-22 Mississippi Hospital Association, Biloxi (Buena Vista Hotel)

20-24 **Basic Hospital Pharmacy,** Columbus (Ohio State University)

20-24 **Dietary Department Administration,** San Francisco (Witcomb Hotel)

26-July 2 ***American Physical Therapy Association,*** Pittsburgh (Penn-Sheraton Hotel)

27-29 Comite des Hopitaux du Quebec, Quebec City (Provincial Exhibition Grounds)

29-July 1 **Nursing Home Administration,** Chicago (AHA Headquarters)

JULY

11-13 **Methods Improvement,** Omaha (Sheraton-Fontenelle Hotel)

18-22 **Hospital Engineering,** Los Angeles (Biltmore Hotel)

AUGUST

1-2 **Safety and Insurance,** Denver (Cosmopolitan Hotel)

1-5 **Hospital Pharmacy (Basic),** Minneapolis (University of Minnesota)

14-19 ***American Society of Hospital Pharmacists,*** Washington, D.C. (Shoreham and Sheraton-Park Hotels)

14-19 ***American Pharmaceutical Association,*** Washington, D.C. (Shoreham and Sheraton-Park Hotels)

15-19 ***National Association of Boards of Pharmacy,*** Washington, D.C. (Shoreham and Sheraton-Park Hotels)

21-26 ***American Association of Blood Banks,*** San Francisco (Jack Tar Hotel)

26-27 ***American Association for Hospital Planning,*** San Francisco (Federal Building and Clift Hotel)

27 ***American Association of Hospital Consultants,*** San Francisco (Fairmont Hotel)

29-Sept. 1 ***American Association of Nurse Anesthetists,*** San Francisco (Civic Auditorium and Sheraton-Palace)

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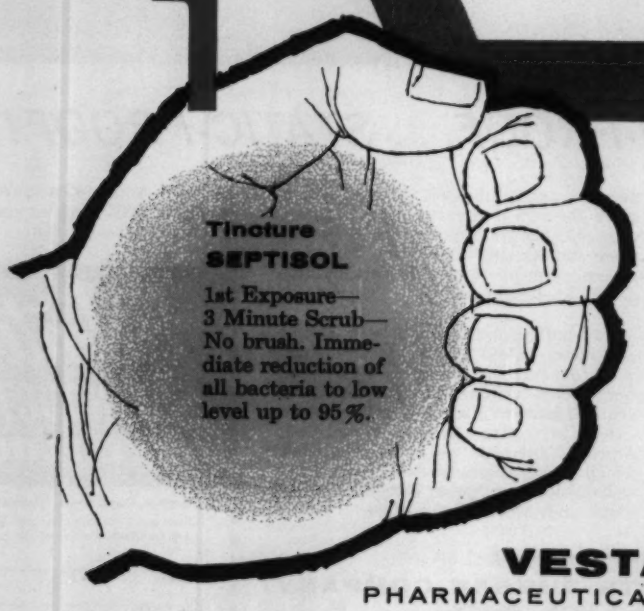
3 dimensional procedure

provides quick effective skin degerming that lasts indefinitely without fear of skin irritation

High bacterial level on skin of person with no previous exposure to hexachlorophene washing, or whose exposure has lapsed for 24 hours or more.

1



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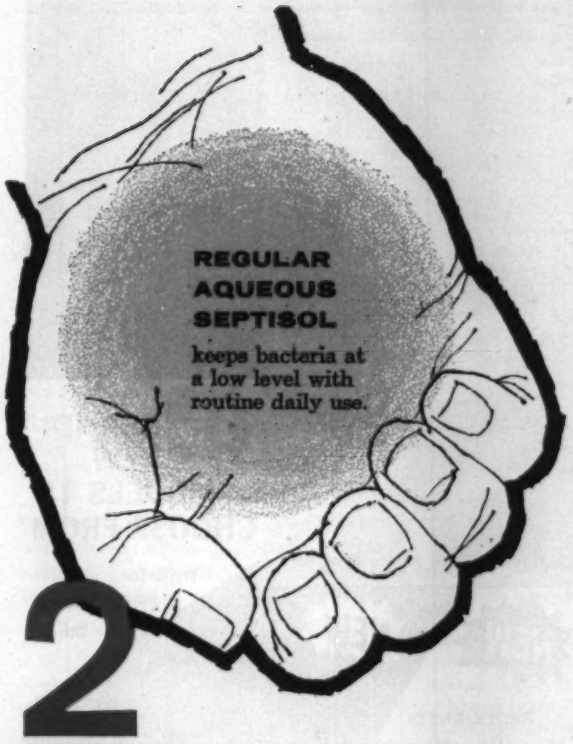
With the *New* SEPTISOL 3-dimensional procedure,

scrubbing time is greatly reduced, effectiveness is increased and the entire method of antiseptic skin preparation is MODERNIZED.



1st DIMENSION (Fast, effective skin degerming)

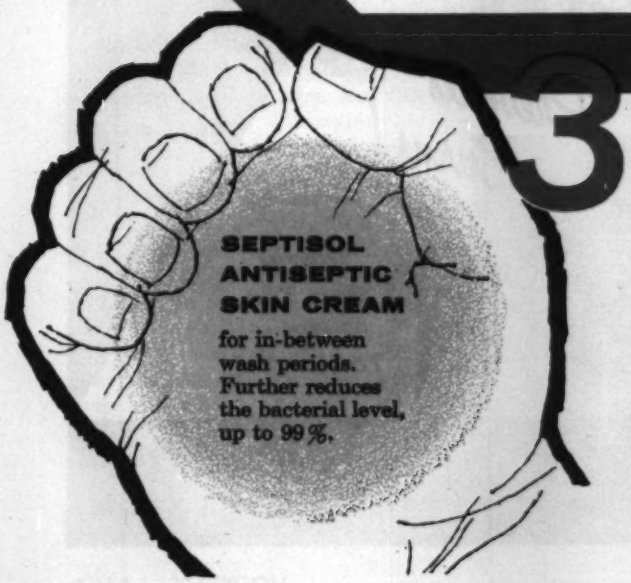
Tincture SEPTISOL (SEPTISOL diluted with 2 parts alcohol) combines the rapid killing power of alcohol, for immediate bacteria reduction, with the residual antibacterial activity of hexachlorophene, deposited in the deep layers of the skin to curb the regeneration of bacteria.

With Tincture SEPTISOL a person with no previous exposure to hexachlorophene may obtain, IN JUST 3 MINUTES OF SCRUBBING (no brush), a bacterial reduction otherwise attainable only in two or more consecutive days using an aqueous hexachlorophene detergent.

Tincture SEPTISOL is recommended for all emergency scrubs, all preoperative patient skin preparation, anyone with no previous exposure to hexachlorophene, whenever washing with hexachlorophene has lapsed for more than 24 hours.

2nd DIMENSION (Routine skin degerming)

REGULAR AQUEOUS SEPTISOL (SEPTISOL diluted with 2 parts water) gives effective residual antibacterial activity, high detergency cleansing action plus won't irritate normal skin. After the complete degerming of the skin has been accomplished by the 1st SEPTISOL Dimension, the routine daily use of REGULAR AQUEOUS SEPTISOL will build-up and maintain the hexachlorophene protection to curb the regrowth of disease causing skin bacteria. REGULAR AQUEOUS SEPTISOL is recommended for: the surgical scrub where there has been exposure to hexachlorophene within 24 hours. Scrub between glove changes, post-operative wash of surgical team and patient, and all regular hand washing by all personnel.



3rd DIMENSION (In-between wash periods)

SEPTISOL ANTISEPTIC SKIN CREAM:—Ideal for periods between washes, after hours, weekends, etc., to maintain the high degree of hexachlorophene protection. Keeps skin feeling fresh and clean. Adds additional hexachlorophene protection with each use. Prevents dryness and skin irritation. Excellent for infant skin lubrication and protection. Treats pyogenic skin infections. A wonderfully soothing massage to prevent patient bed sores.

Try the NEW SEPTISOL 3-DIMENSION procedure in your hospital.

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For Patients' Rooms, Laboratories, Convalescent Homes, Homes for the Aged, etc.

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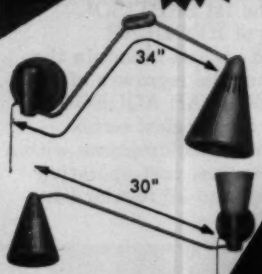

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NEW

NEW

NEW

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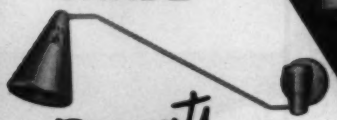


Prevents Burns!

"Never Gets Too Hot To Handle"

swivelier COMPANY, INC.

LOOK FOR THE SWIVELIER TRADEMARK

Personnel physician

The question frequently arises as to whether it is permissible for an intern or resident in a hospital to be assigned to act in the capacity of personnel physician for the purpose of examining applicants for employment, as well as to examine personnel during sick call.

Each resident would be assigned to this service for a period of two hours a day for one week during a year of residency. Would this affect the rating of the hospital?

It is permissible for any licensed physician to be assigned to look after the personnel of a hospital. Even an intern, although not licensed, could carry out this duty under the direct supervision of a licensed resident or a staff physician, in much the same manner as he treats the patients in the outpatient department.

All the work of an intern or resident in a hospital should be supervised by a member of the medical staff. If this rule is followed, there will be no effect on the rating of your hospital.

—J. R. ANDERSON, M.D.

Education in infections

Our hospital infections committee is interested in setting up an educational and training program concerned with the prevention and control of hospital-acquired infections. What suggestions could you make to assist us?

We would suggest that you refer to the "Guide for Organizing Hospital In-Service Training Programs," PHS Publication No. 692, prepared by the Communicable Disease Center, Atlanta. Reviewed prior to publication by the American Hospital Association, the guide was mailed to institutional members (Types I, II, III and VI) in July 1959.

The guide is divided into four sections headed as follows: (1) General Considerations, (2) Program Content, (3) Maintaining the Training Program and (4) Training Aids.

The first section covers such topics as planning a training committee, goals of the training program and program structure. The second furnishes training program outlines specifically prepared for physicians, nurses and other hospital personnel. The third provides suggestions about keeping the training program active. The last section is a short reference list of pertinent literature and movies which can be used in the program.

Additional copies of the guide are available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., for 30 cents.

—J. ALLAN MAHONEY, M.D.

Gifts to hospitals

Should undesignated gifts and legacies to hospitals be accounted under capital funds or as a part of current income?

The manual *Uniform Chart of Accounts and Definitions for Hos-*

Here's help in

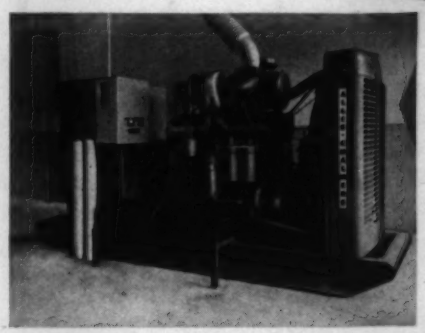
CHOOSING THE RIGHT STANDBY ELECTRIC POWER

for your hospital

This engine generator set Estimating Kit provides simplified information on:

- standby power requirements in hospitals
- explanation of engine generator set components
- starting systems and switchboard types
- exhaust and cooling systems
- suggested specifications for entire system
- sheets for analyzing load requirements
- other helpful information

Write direct for the Estimating Kit that helps you determine engine generator set requirements in your hospital —



or see your Allis-Chalmers dealer. He will be glad to assist in determining your needs. Allis-Chalmers, Milwaukee 1, Wisconsin.

This Allis-Chalmers 21000 Sure-Power generator set protects vital services in case of power failure at a hospital in New England.

ALLIS-CHALMERS

POWER FOR A GROWING WORLD

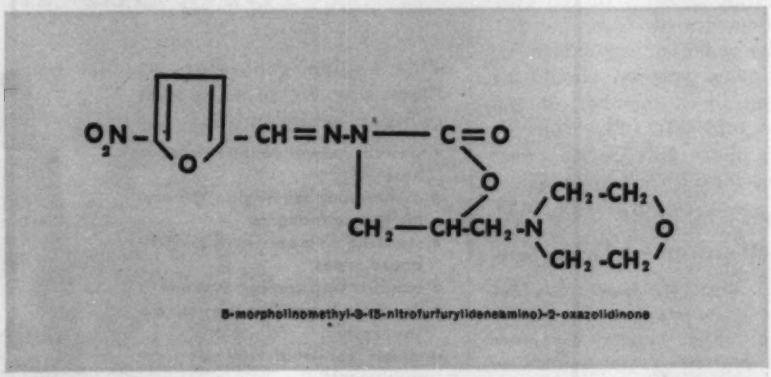
BG-39

Announcing

ALTAFUR™

brand of furaltadone

a new member in the nitrofuran family



5-morpholinomethyl-3-(5-nitrofurfurylideneamino)-2-oxazolidinone

the first nitrofuran effective orally in systemic bacterial infections

The promise of

ALTAFUR

in clinical medicine

Extensive laboratory and clinical investigative effort has been devoted to the screening and evaluation of nitrofuran compounds in the quest for agents with systemic antibacterial effectiveness. ALTAFUR is the achievement of this program.

In vitro, ALTAFUR is effective against the following gram-positive and gram-negative organisms (isolated from clinical infections):

Organism	*Sensitive*	*Resistant*	*% Sensitive*
Staphylococci*	181	1	99.4
Streptococci	65	1	98.5
D. pneumoniae	14	0	100.0
Coliforms	34	3	91.8
Proteus	5	5	50.0
A. aerogenes	8	0	100.0
Ps. aeruginosa	5	4	55.5

*Includes many strains resistant to antibiotics.

As with other nitrofuran compounds, development of bacterial resistance is negligible.

Clinically, ALTAFUR has proven most effective in the treatment of a variety of conditions including *pulmonary infections (pneumonia, empyema, bronchiolitis), upper respiratory tract infections, abscesses, cellulitis, pyodermas, septicemia/bacteremia and various wound infections.* ALTAFUR has produced cures in 75% of cases, and significant improvement in 10%.

To date, ALTAFUR has been used most extensively in staphylococcal infections with a cure rate of 66% and an improvement rate of 20%. Of particular importance, a number of these patients had not responded to previous therapy with antibiotics or other chemotherapeutic agents.

In common with the other available nitrofurans, ALTAFUR has a low order of side effects. Nausea and emesis occur occasionally but these can be minimized or eliminated through dosage adjustment and by giving the drug with meals and with food or milk on retiring. In the two instances in which a neutropenia developed, ALTAFUR was not clearly implicated. There has been no cross-sensitization of patients with other antibacterials.

The average adult dose is one 250 mg. tablet q.i.d. with meals and food or milk at bedtime. For severe staphylococcal infections, the dosage may be increased to approximately 30 mg./Kg. (13.5 mg./lb.) body weight per day, administered in four equally divided doses. The average length of therapy is five to seven days. Because this is a new drug, therapy probably should not be continued for more than 14 days except in severe or complicated cases, such as osteomyelitis, endocarditis, bacteremia (septicemia), etc.
Additional information may be obtained from the Medical Director, Eaton Laboratories.

ALTAFUR is available as quadrisected, chartreuse-colored tablets of 50 mg. and 250 mg. ALTAFUR Sensi-Discs, for bacterial sensitivity tests, are available from Baltimore Biological Laboratory.

NITROFURANS—a *unique* class of antimicrobials—neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK

pitals, published by the American Hospital Association, states the following under Account 531, General Contributions, Donations, Legacies and Bequests:

"All contributions, donations, bequests, etc., made without restriction by the donors, should be credited to this account. However, in cases of large donations, the amounts should be segregated as a separate account. In case of large donations which would distort the periodic income statement, the amounts so received should be segregated in a separate account so that the amounts may be easily identified. This account also should be used to record income from hospital bazaars, entertainments and similar activities or drives intended to raise general funds for the hospital. This account should be divided into as many subaccounts as the hospital may deem necessary to show the different types or sources of income received.

"Grants from Community Chests, foundations and government agencies, and donated services and commodities should not be credited to this account, but to the appropriate accounts that follow.

"Separate subaccounts may be provided as follows:

531.1 General Contributions, Donations (from individuals, churches, etc.).

531.2 Proceeds from Benefits and Entertainments."

If your hospital does not have a copy of this manual, it is available from Association headquarters.

If you wish more detailed discussion regarding the legal aspects of endowments, I would suggest Volume I of *College and University Business Administration* published by the American Council on Education, 1785 Massachusetts Ave., N.W., Washington 6, D.C.

—ELTON TEKOLSTE

Certificates for trustees

We have received a suggestion that a certificate be given to hospital trustees whose terms have expired, in recognition of their services to the hospital.

Does the American Hospital Association have such a certificate available?

The American Hospital Association has not developed a certificate to be given to trustees whose terms have expired. However, your question brings up a subject which is worth our further consideration.

I would suggest that the secretary of the hospital's board write a brief letter of commendation. After it is appropriately typed, it could be framed for presentation to the board members at the hospital's annual meeting.

No doubt you are aware that a number of hospitals elect retiring trustees to the position of honorary trustee at about the age of 70 or 75. This arrangement permits them to receive notices and minutes to meetings, to attend meetings and to express opinions without, however, the right of vote. Such a procedure has the advantage of keeping faithful board members interested in the hospital but removes any sense of responsibility which they might find burdensome.—HIRAM SIBLEY

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

SAVE

STORAGE SPACE AND EXPENSE

by reducing needle inventories with the

ALL-PURPOSE

DEKNATEL 'K' NEEDLE

U.S. Patent No. 2,869,550

A SIGNIFICANT ADVANCE IN SURGICAL NEEDLES

Sharper than a cutting edge needle but leaves a taper point hole!

The Deknatel 'K' Needle is all-purpose. You can now stock a single Deknatel 'K' Needle instead of the two formerly required – cutting and taper. Handling is simplified. You save on storage space and expense. Efficiency is increased at the O.R. table.

For sample and details of specific advantages of the Deknatel 'K' Needle in all types of surgery, write–

DEKNATEL 96-30 222 Street • Queens Village 29, New York

Closer Control of airborne contamination in hospitals seen, as researchers reveal new findings

In a study of St. Barnabas Hospital, Minneapolis, Minnesota, researchers looked into a practical method for reducing one of our biggest headaches in hospitals.

Newell P. Weed, Jr., Chairman
Trustees' Building Committee
St. Barnabas Hospital
Minneapolis, Minnesota

"The results of this study are very encouraging," reports Mr. Newell P. Weed, Chairman of the Trustees' Building Committee of St. Barnabas Hospital. "While the tests are of a preliminary nature and could be subject to variation, the results are regarded by bacteriologists as *typical*. We hope they will prove to be a significant step toward the control of airborne contamination in hospitals."

Tests at St. Barnabas Hospital point to the elimination of a dangerous source of infection

Findings reveal that Electronic Air Cleaners significantly reduce airborne bacteria and mold spores

"When we planned our 306 bed new general acute hospital, we anticipated the problem of airborne contamination," says Mr. Newell P. Weed, Chairman of the Trustees' Building Committee of St. Barnabas Hospital. "We were aware that one way in which contaminated air is introduced into a building is through its air conditioning system. To reduce this hazard as much as possible, we installed an Electronic Air Cleaner in every fan system.

"We were convinced that electronic air cleaning was the best available method for reducing airborne dust and dirt. However, to our knowledge, little objective research had been done on its ability to remove bacteria from circulated air in hospital installations. Therefore, we decided to study our own installation upon its completion in 1959, to determine its efficiency in removing airborne bacteria and mold spores."

TEST PROCEDURES:

On November 23, 1959, two tests were made of one of the Honeywell Electronic Air Cleaner installations at St. Barnabas Hospital. The first test was made at 8:05 a.m. The second was made at 11:55 p.m.

Airborne bacteria and mold spore samples were taken from the air before and after it had passed through the electronic air cleaning system. The system contained a pre-filter. Each sample was collected through a Casella slit sampler for five minutes. This gave a total sample volume of five cubic feet. The airborne particles were accelerated at a great enough velocity in passing through the slit to cause them to impinge on a rotating agar-filled petri dish beneath the slit.

The samples were then cultured, and the bacteria and mold spore counts made.

RESULTS:

The *unretouched* color photographs on the opposite page show petri dishes containing the cultured samples taken from the two locations in the air handling system. The bacteria and mold spore counts are listed in the table at the right. The significant reduction in airborne bacteria and mold spores reveal the efficiency of the electronic air cleaning system.

The variation in the two samples at location A taken at different times of the day is attributed to the difference in bacteria and mold spore generation at those times. At 8:05 p.m., there was considerable activity within the building; traffic outside the hopsital was heavy. Later, at midnight, there was little inside or outside activity.

Bacteria and Mold Spore Counts

	Time: 8:05 p.m.		Time: 11:55 p.m.	
	Location A	Location B	Location A	Location B
Colonies in 5 Cubic Feet	127	7	13	1
Total Colonies Per Cubic Foot	25.4	1.4	2.6	0.2

LOCATION A

before passing through the Electronic Air Cleaner

COUNT: 25.4 colonies per cubic foot

LOCATION B

after passing through the Electronic Air Cleaner

COUNT: 1.4 colonies per cubic foot

TIME
8:05 P.M.

COUNT: 2.6 colonies per cubic foot

TIME
11:55 P.M.

COUNT: 0.2 colonies per cubic foot

Honeywell Air Cleaning Systems assure the best possible protection against airborne contamination

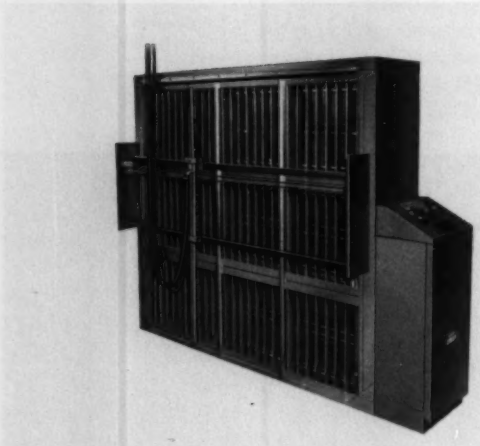
Honeywell offers you a combination of the Honeywell Electronic Air Cleaner and Activated Charcoal Filter in the world's finest air cleaning system.

A Honeywell Air Cleaning System will remove 90% of all dirt that passes through your air conditioning system—trap particles as small as 1/2,500,000 of an inch. It will also prevent the accumulation of dust and dirt in your ventilating ducts. This, too, can be a dangerous source of contamination.

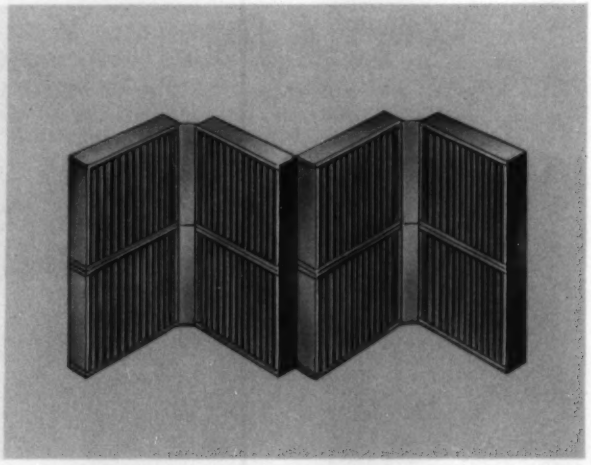
It will remove odors—help cut your air conditioning costs because less outside air is needed for ventilation. And, in some cases, it will enable you to install a smaller air conditioning system, thus offsetting its own cost.

A Honeywell Air Cleaning System will assure a fresh, clean atmosphere throughout your hospital—contribute to patient comfort, lower cleaning and redecorating costs and help promote a more efficient nursing staff.

For additional information about Honeywell Air Cleaning Systems, call your architect or engineer. Or write Honeywell, Dept. H-60, Minneapolis 8, Minnesota.



Honeywell Electronic Air Cleaner removes 90% of all airborne dirt



Honeywell Activated Charcoal Filter removes odors

75th YEAR — PIONEERING THE FUTURE

Honeywell

First in Control

SINCE 1885

REPORT FROM WASHINGTON—Staffing problems were among the subjects discussed at a Senate subcommittee's hearings on Veterans Administration hospitals. William S. Middleton, M.D., VA's chief medical director, reported a reduction in professional nursing staff vacancies and general acceptance of lay managers in VA hospitals. Dr. Middleton also testified on costs of care and drugs, ideal hospital size, care of chronically ill and aged, and use of outside laundry services. *(Details p. 143).*

• The president of the Pharmaceutical Manufacturers Association argued at recent drug hearings that the cost of living rise far exceeded the cost of drugs increase. Austin Smith, M.D., called the cost of research by the pharmaceutical industry a "staggering investment". Sen. Estes Kefauver (D-Tenn.), chairman of the Senate subcommittee holding the hearings, charged that the drug industry has a greater monopoly than any other manufacturing group. *(Details p. 144).*

• Two republican senators last month issued a miniority report which disagreed with the recommendations made by the Senate Subcommittee on Problems of the Aged and Aging for a government program to finance health care for social security beneficiaries. Senators Everett Dirksen (R.-Ill.) and Barry Goldwater (R.-Ariz.) said the problem was "essentially a local responsibility". *(Details p. 146).*

ILLINOIS PHYSICIANS SPONSOR INSURANCE FOR AGED—A special low-cost insurance program for persons 65 years old or older has been prepared by the Illinois Blue Shield Plan on instructions from the house of delegates of the Illinois State Medical Society. The program, underwritten by the Plan, provides for payment of surgical and inhospital medical expenses. The surgical allowance is limited to $200 for a 90-day period. The inhospital medical care allowance provides for $5 for each of the first five daily visits and $3 for each of the next 25. The patient is eligible for another 30 days of inhospital medical care after being out of the hospital for 90 days.

According to Joseph T. O'Neill, M.D., president of the medical society, "the fact that people can get these benefits over and over again, either for the same or a different condition, is an outstanding feature of this program. Pre-existing conditions also are covered after 180 days of membership."

The special program, expected to cost approximately $1.65 a month per individual, provides also for diagnostic x-ray service, radiation therapy, clinical and surgical pathology, anesthesia, shock therapy and diagnostic skin tests.

A Blue Cross companion program is in the final stages of development, according to Robert T. Evans, executive director of Hospital Service Corp., the Illinois Plan. The program will be specially designed for the 65 and over age group, and it is expected that it will provide coverage for 30 days of hospitalization.

CARE OF CHRONICALLY ILL: A SUBJECT AT PROTESTANT HOSPITAL MEETING—The currently available care for the chronically ill leaves much to be desired, but improvement can be expected in the sixties, according to the administrator of a Hays, Kan., hospital. He spoke during the 39th annual convention of the American Protestant Hospital Association last month. Addressing the Methodist hospitals section at the Columbus, Ohio, meeting, Austin J. Evans advocated a comprehensive program, coordinated through a rehabilitation center, to provide proper care for the chronically ill and outlined standards such care should meet.

• Basic categories of nursing home care were recommended at the convention by a Minneapolis nursing home administrator.

• Arthur S. Flemming, Secretary of Health, Education, and Welfare, suggested measures that should be taken to prevent or eliminate dependency.

• Legal problems of hospitals, including the use of consent forms, received attention at the Baptist section of the APHA convention from John F. Horty, a professor at Health Law Center, Pittsburgh. *(Details pp. 149, 150).*

FIRM CHARTERED IN MARYLAND TO DETERMINE PATIENT COSTS, REIMBURSEMENTS—An independent, nonprofit organization has been formed in Maryland to conduct systematic examinations of financial and statistical hospital records. The state will follow the cost figures as the basis for payment of indigent care; the Maryland Blue Cross Plan will use them in setting hospital reimbursement formulas. The Maryland Department of Health, Maryland Hospital Service, Inc. (Blue Cross) and the Maryland Hospital Council, the three organizations responsible for the development of the new service, will share the expenses of its operation. *(Details p. 149).*

COURT DECISION IN COLORADO HOLDS HOSPITALS EXEMPT FROM COLLECTIVE BARGAINING—A legal question which arose after a union attempted to organize a Denver hospital's nonprofessional employees was settled last month in a Colorado Supreme Court decision. The court, which reversed an earlier ruling of a district court, decreed that hospitals were exempt from the Colorado Labor Peace Act, and thus exempt from compulsory union representation elections and collective bargaining. *(Details p. 152).*

Worth Quoting

"The purpose of the medical reader (and of the hospital reader) is to broaden his view, not merely to find a simplified set of rules for earning his bread and butter"—Joseph Garland, M.D., *editor*, New England Journal of Medicine.

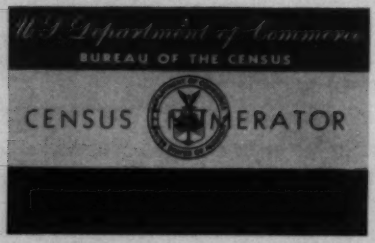


Fig. 1

A special report on the

HOSPITALS AND THE

WITHIN THE next two or three weeks, enumerators from the Bureau of the Census will visit the 6818 hospitals in the 50 states to gather information about the 1.3 million patients who will be occupying hospital beds on April 1, 1960. This hospital count will be an important part of the prodigious effort to obtain data about the estimated 180 million persons in the United States.

Every 10 years since 1790 in the years ending in "0", according to a constitutional requirement, a census of the population of the United States has been taken. The forthcoming census will be the eighteenth. Early in April, census enumerators, or "census takers" as they are more commonly called, will go to every place of dwelling—homes, hospitals, jails, ships, trailers, military establishments and others—to complete the eighteenth census.

Working out of approximately 400 district offices, in areas roughly corresponding to congressional districts, 160,000 enumerators will begin the count as close to April 1, 1960, as is possible. Each carries a card (see Fig. 1) which he will show on request.

When an enumerator comes into a hospital sometime after April 1, he will be interested in counting only those patients who were hospitalized as of April 1. Even if he arrives on April 10, he will want to know who the persons were who were hospitalized on April 1. He will not count babies born on April 2, for example. For the Bureau of the Census, these do not exist—whatever may be the opinion of the nursery staff or the proud parents. Conversely, patients hospitalized on April 1 who died after that date still exist for the Bureau. They must be counted.

The Bureau divides hospitals into two classes—"general hospitals" where patients, whose usual places of residence are elsewhere, receive short-term care and "institutions" where patients receive long-term care and which are the usual places of residence of these patients. The former are acute short-term hospitals and the latter are chronic long-term hospitals. Special wards in general hospitals, such as psychiatric and tuberculosis, for census purposes are classed as institutions.

These classifications enable enumerators to assign all persons in their districts to their normal permanent residential areas. Prior to the visit of the enumerators, hospitals will receive an "Individual Census Report" form (see Fig. 2) for each transient resident patient and an "Advance Census Report" form (see Fig. 3) for each permanent resident patient.

HOW HOSPITALS CAN HELP

Representatives of the Bureau offered the following suggestions to speed up the enumerators' work in hospitals and institutions:

1. See that patients who are able

FREE TELKEE booklet answers that question for you; shows how TELKEE saves you time and money, gives you new convenience.

STOPS time wasted locating lost or borrowed keys

MINIMIZES expensive lock replacement and repairs

ORGANIZES all your keys in one orderly system

What's more, TELKEE guarantees maximum security and privacy—keeps keys in authorized hands, always.

Offices, factories, stores, schools, housing, hospitals . . . there's a TELKEE System to fit every size and type of application. TELKEE solves every key problem, efficiently, inexpensively.

FREE—send today!

TEL KEE

The MOORE KEY CONTROL® System

P. O. Moore, Inc., Glen Riddle 18, Pa.
Send FREE TELKEE booklet
NAME_____
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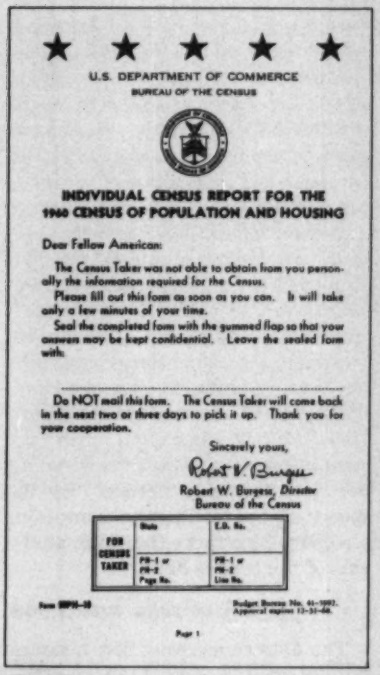
CITY_____ ZONE___ STATE_____

eighteenth U.S. census

CENSUS



U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INDIVIDUAL CENSUS REPORT FOR THE 1960 CENSUS OF POPULATION AND HOUSING

Dear Fellow American:

The Census Taker was not able to obtain from you personally the information required for the Census.

Please fill out this form as soon as you can. It will take only a few minutes of your time.

Seal the completed form with the gummed flap so that your answers may be kept confidential. Leave the sealed form with:

Do NOT mail this form. The Census Taker will come back in the next two or three days to pick it up. Thank you for your cooperation.

Sincerely yours,

Robert W. Burgess, *Director*
Bureau of the Census

FOR CENSUS TAKER	State	E.D. No.
	PN-1 or PN-2 Page No.	PN-1 or PN-2 Line No.

Form BPN-10 — Budget Bureau No. 41-1997. Approval expires 12-31-60.

Page 1

Fig. 2

to prepare the ICR's and the ACR's do so in advance of the enumerators' visits.

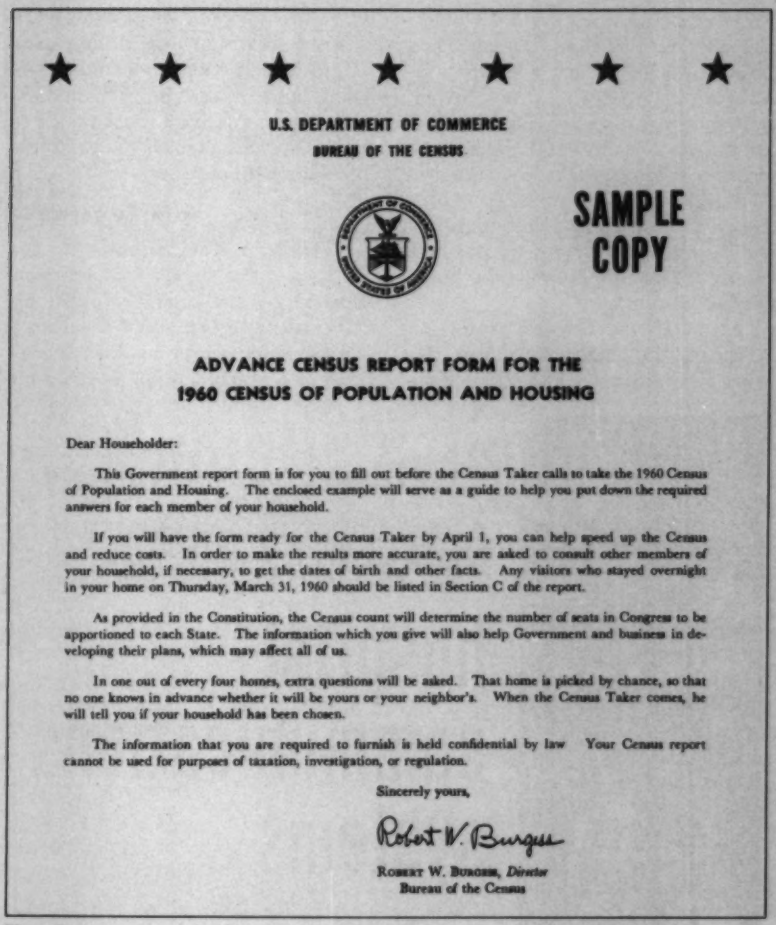
2. For those unable to do so, have hospital clerical personnel complete the forms from the hospital's records.

3. As close to April 1 as possible, prepare a roster of all patients in the hospital for the enumerator's use. The roster should include the patients' names, ages, sexes and usual home addresses.

4. If possible, assign one or more persons to assist the enumerator with his work. This will consist of copying from hospital records, interviewing patients and so forth.

5. Call the local district office for further information.

It should be clearly understood



U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SAMPLE COPY

ADVANCE CENSUS REPORT FORM FOR THE 1960 CENSUS OF POPULATION AND HOUSING

Dear Householder:

This Government report form is for you to fill out before the Census Taker calls to take the 1960 Census of Population and Housing. The enclosed example will serve as a guide to help you put down the required answers for each member of your household.

If you will have the form ready for the Census Taker by April 1, you can help speed up the Census and reduce costs. In order to make the results more accurate, you are asked to consult other members of your household, if necessary, to get the dates of birth and other facts. Any visitors who stayed overnight in your home on Thursday, March 31, 1960 should be listed in Section C of the report.

As provided in the Constitution, the Census count will determine the number of seats in Congress to be apportioned to each State. The information which you give will also help Government and business in developing their plans, which may affect all of us.

In one out of every four homes, extra questions will be asked. That home is picked by chance, so that no one knows in advance whether it will be yours or your neighbor's. When the Census Taker comes, he will tell you if your household has been chosen.

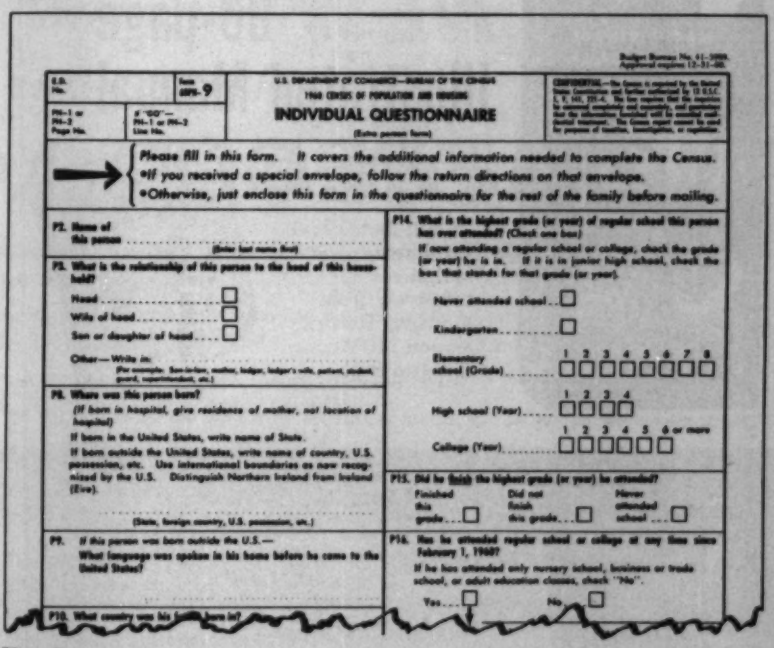
The information that you are required to furnish is held confidential by law. Your Census report cannot be used for purposes of taxation, investigation, or regulation.

Sincerely yours,

Robert W. Burgess

ROBERT W. BURGESS, *Director*
Bureau of the Census

Fig. 3



Budget Bureau No. 41-3098. Approval expires 12-31-60.

E.D. No. — Form BPS-9 — U.S. DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS — 1960 CENSUS OF POPULATION AND HOUSING

INDIVIDUAL QUESTIONNAIRE

(Extra person form)

CONFIDENTIAL—The Census is required by the United States Constitution and further authorized by 13 U.S.C. 1, 9, 141, 221-4. The law requires that the answers be returned completely and correctly, and guarantees that the information furnished will be considered confidential. No Census report cannot be used for purposes of taxation, investigation, or regulation.

PN-1 or PN-2 Page No. — If "YES"—PN-1 or PN-2 Line No.

Please fill in this form. It covers the additional information needed to complete the Census.
•If you received a special envelope, follow the return directions on that envelope.
•Otherwise, just enclose this form in the questionnaire for the rest of the family before mailing.

P2. Name of this person ..... (Enter last name first)

P3. What is the relationship of this person to the head of this household?
Head ☐
Wife of head ☐
Son or daughter of head ☐
Other—Write in: ..... (For example: Son-in-law, mother, lodger, lodger's wife, patient, student, guard, superintendent, etc.)

P8. Where was this person born?
(If born in hospital, give residence of mother, not location of hospital)
If born in the United States, write name of State.
If born outside the United States, write name of country, U.S. possession, etc. Use international boundaries as now recognized by the U.S. Distinguish Northern Ireland from Ireland (Eire).
..... (State, foreign country, U.S. possession, etc.)

P9. If this person was born outside the U.S.—
What language was spoken in his home before he came to the United States?

P10. What country was his father born in?

P14. What is the highest grade (or year) of regular school this person has ever attended? (Check one box)
If now attending a regular school or college, check the grade (or year) he is in. If it is in junior high school, check the box that stands for that grade (or year).
Never attended school ☐
Kindergarten ☐
Elementary school (Grade) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
High school (Year) ☐1 ☐2 ☐3 ☐4
College (Year) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

P15. Did he finish the highest grade (or year) he attended?
Finished this grade ☐ — Did not finish this grade ☐ — Never attended school ☐

P16. Has he attended regular school or college at any time since February 1, 1960?
If he has attended only nursery school, business or trade school, or adult education classes, check "No".
Yes ☐ — No ☐

Fig. 4

that every hospital patient must fill out an ICR form, even if he completed one before entering the hospital. Every institutional pa-

tient must complete an ACR form. As part of a national 25 per cent sample, selected on a systematic probability sampling basis, every fourth institutional patient will be given an "Individual Questionnaire" (see Fig. 4) to complete. General hospital patients will not receive these forms, only patients in hospitals designated by the Bureau. These forms must be completed also.

Although the Bureau prefers to prepare the "Questionnaire" by interview rather than from records, this will not be possible with many patients in institutions, such as mental patients, isolated patients and others. In such instances, the enumerator must resort to the hospital's records to complete the questionnaire.

FROM ICR TO FOSDIC

All information supplied on the ICR's and the ACR's will be transcribed by the enumerator to his "Permanent Census Schedule." Every fourth entry in the "Schedule" is a starred item, which simply means that this individual has been selected on a systematic probability sampling basis to complete the "Individual Questionnaire." The schedule is completed by using a special pencil to fill in small circles. When the schedule arrives at the central office in Washington, D.C., the information it contains is microfilmed and then prepared for tabulation by a special machine called "FOSDIC."

FOSDIC is really an abbreviation for "Film Optical Sensing Device for Input to Computer." This machine, which operates on a principle similar to that of a television picture tube, scans the microfilmed census reports and transfers the information to magnetic tapes which are then processed through an electronic computer. The computer can carry through a whole sequence of operations without human intervention, determining successive operations from the results previously obtained. It can also work at a speed many times faster than any other type of data-processing equipment. Since the computer also has a large capacity for storing data, it can refer to these data at any stage of the operation. Work, therefore, can be completed in a small fraction of the time formerly needed. By its speed of operation, the computer also permits a more thorough analysis of the census data.

CENSUS DATA PUBLICATION

The data concerning institutional patients will be included in a report titled "Institutional Population" to be published later in the year. The 1950 report disclosed that one per cent, or 1.6 million persons were institutional residents. Of this number, 614,000 were in mental hospitals; 76,000 were in tuberculosis hospitals; 299,000 were in homes for the aged and dependent; 134,000 were in homes and schools for the mentally handicapped, and 21,000 were in homes and schools for the physically handicapped.

It is anticipated that the 1960 census will show an increase in each of these categories. Data concerning patients in psychiatric, tuberculosis and other special or chronic disease wards in general hospitals will also be made available. ■

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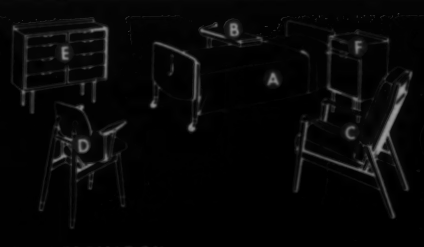

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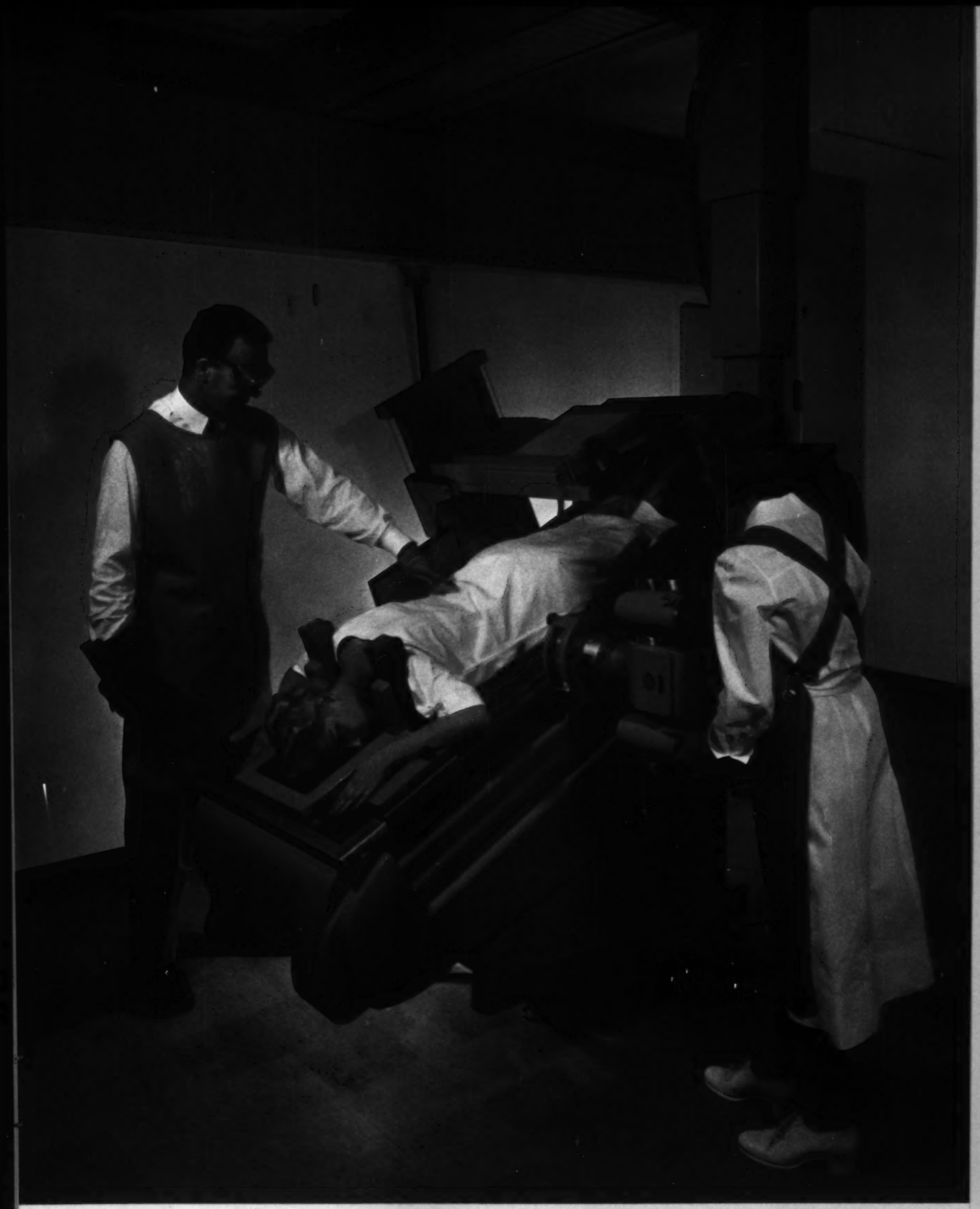

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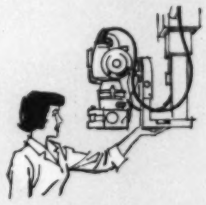

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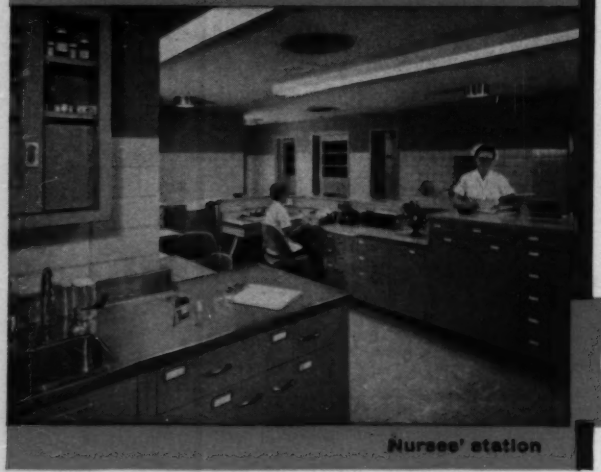

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EVEN on her way to x-ray, a young patient at Children's Hospital, Akron, Ohio, wants her favorite doll and big balloon.

...hinions and ideas

'Loveworn' toys best for children, nurse writes

Because children need as much reassurance as possible during a stay in the hospital, the Palo Alto-Stanford University Hospital Center in Palo Alto, Calif., advises parents to bring loveworn—rather than new—toys to pediatric patients. Peggy Card, R.N., of the hospital's pediatric department, explains in an article in *RN* that when everything is new and strange, a favorite toy from home can help provide some of the reassurance that a child needs.

If a child requires long-term hospitalization, Miss Card says, parents are encouraged to bring small presents one at a time rather than many large, expensive presents all at once. Parents are also advised to take some of the toys home when they begin to accumulate in large numbers, because too many toys make the child confused and irritable.

Parents are also encouraged to bring a shoe box or small suitcase so that the child may put away his own toys.

Parents frequently ask for suggestions as to the types of toys that would be best to bring in addition to the loveworn ones from home. In such instances, hospital staff members recommend magic slates, toy soldiers, paper dolls, coloring books, a magnifying glass, a magnet, beads to string, and inexpensive grooming sets (brush, comb, ribbons, hair tonic, etc.). Parents are urged not to bring modeling clay and incomplete model kits. ■

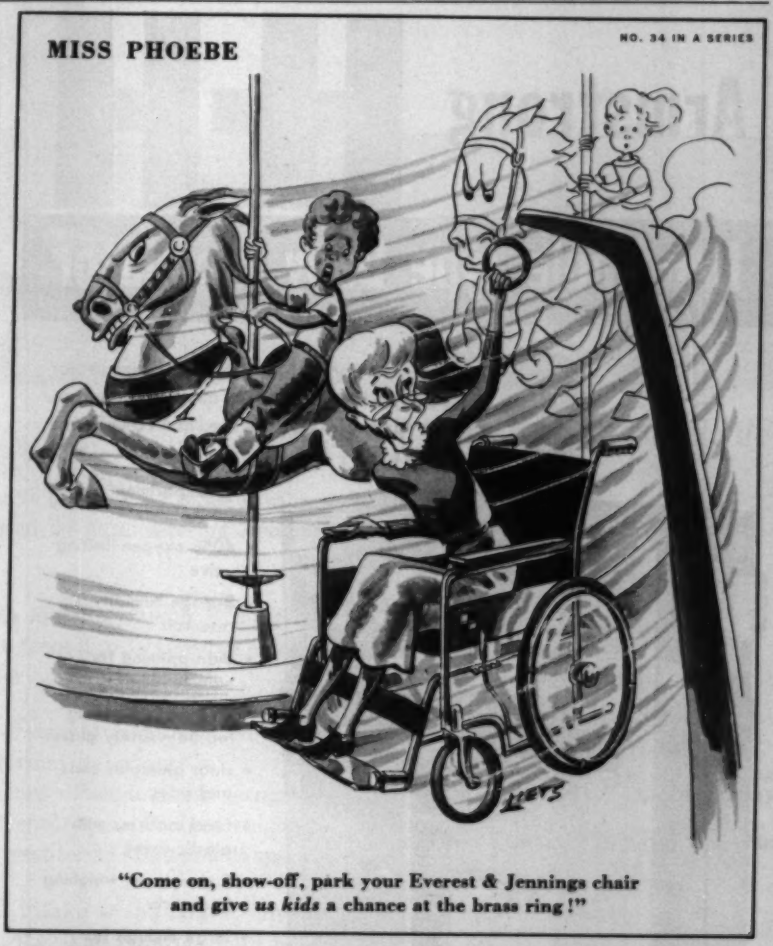
Wide publicity accorded South Dakota meeting

An alert president and cooperative radio and news editors brought unusually wide publicity for the 1959 annual meeting of the South Dakota Hospital Association. A panel discussion on rehabilitation, a feature of the convention program, was broadcast to a five-state audience in North Dakota, South Dakota, Nebraska, Iowa and Minnesota over radio station WNAX, Yankton, S.D.

The program was also carried by the local Yankton radio station, KYNT, and was afforded statewide coverage over the Associated Press news wire.

The rehabilitation story thus reached more than two million readers and listeners without cost to the South Dakota Hospital Association.

Sister M. Rosaria, O.S.B., then



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president of the South Dakota Hospital Association, enlisted the support of the radio station program directors. Sister Rosaria reports that they were quick to cooperate in carrying the program.

The radio stations carried the program as a public service. Each radio station provided the recording equipment and an engineer to record the half-hour program during an afternoon session of the convention. The actual broadcast of the panel presentation took place the same evening.

The six panel members were advised in advance to limit their presentation to the allotted radio broadcast time. A hospital administrator, dietitian, occupational therapist, speech therapist, physical therapist, and a counsellor for vocational rehabilitation were the panelists. ■

Hospital tape records nursing shift reports

To help solve the problem of incomplete and inaccurate communication among nurses from shift to shift, Midland (Mich.) Hospital tape records its nursing shift reports. At the suggestion of Margaret Loessel, the hospital's director of nursing, tape recorders have been placed in the nursing stations of the 160-bed hospital for recording messages from nurses. Messages recorded include the use and location of new equipment, illness of an employee, substitution of a physician in another's absence, references to new policies posted, conditions of patients, and advice regarding special observations and/or care of patients.

Miss Loessel's project was the grand award winner in the 1959 Michigan Hospital Association Hospital Achievements Contest.

Miss Loessel reports that although it takes time for the staff to become accustomed to using the recorder and listening to the reports, she believes that the advantages far outweigh the disadvantages. Advantages of this system are given as follows:

1. When messages are recorded immediately, less is forgotten.
2. Tactful, spoken messages are often better than written notes.
3. Less time is needed for giving reports at change of shifts.
4. Part-time personnel reporting for duty during a nursing shift may be quickly brought up to date.
5. Department heads, such as the director of nursing, may more easily record comment or commendation, since they are not always able to see all persons, each shift, each day. Tape recording of messages helps to avoid false rumors and false "quotes".
6. One nurse may record a question for another and receive the answer either verbally or recorded.
7. Suggestions for improvements regarding policies or procedures may be recorded while they are still "fresh". Such suggestions are often more easily spoken than written.
8. Two shifts can, if it is desired, hear reports from the two previous shifts.
9. Tape recordings help to reduce hasty, incomplete shift reports and neglect of details.
10. Nurses like it.
11. Tape recordings help to insure better reporting and to build rapport which ultimately means better patient care. ■

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After oral ingestion, 3% of the total intake is the largest amount of Neomycin demonstrated in the urine. The bulk of Actol is excreted in the feces, permitting effective bactericidal concentration in the intestines.*

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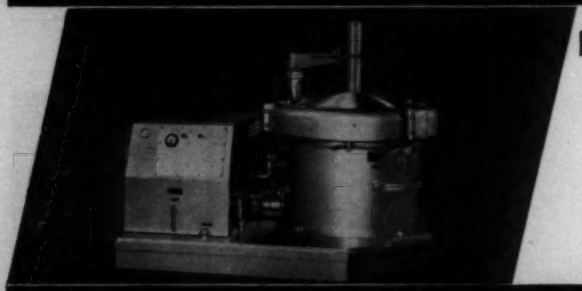

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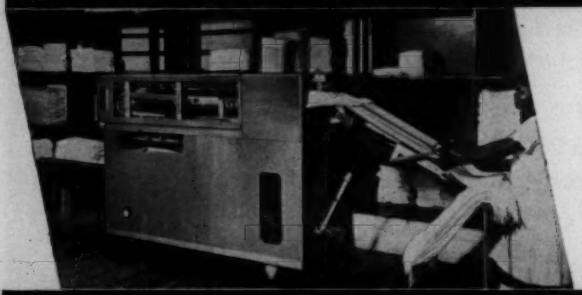

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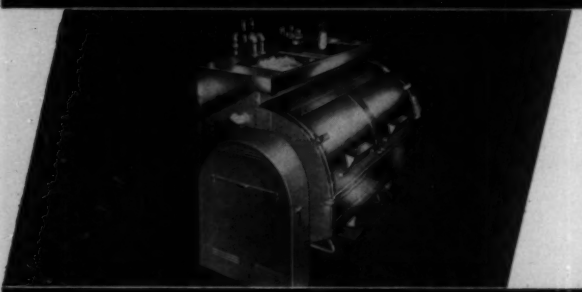

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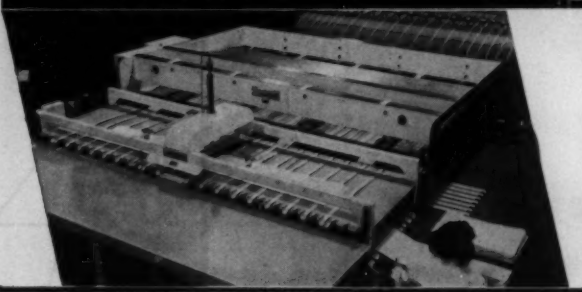

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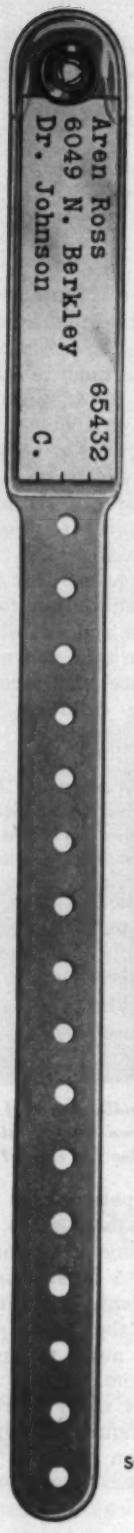

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- countersigning narcotic orders
- recording the physician's narcotic number on order sheet
- use of the anesthetic gas Fluothane®
- confidential treatment of information on patients
- charts for isolation patients

Is a physician required to countersign the narcotic order written by an intern?

It is not necessary nor is it required by the Joint Commission that physicians countersign narcotic orders written by interns.

* * *

Is a physician required to chart his narcotic number on the order sheet?

The Joint Commission does not require a physician to chart his narcotic number on the order sheet.

It would be advisable to call or write to the internal revenue department in your state regarding this matter. Better yet, your state hospital association might check on this point and report on it to all hospitals in the state.

* * *

Our anesthesiologist desires to use the new anesthetic gas Fluothane® (halothane) and wants me to purchase some for the hospital. Shall I?

The answer is a qualified yes, because your anesthesiologist should not use it unless he has had special training and instructions in its usage, its indications and contraindications. Fluothane® is a new inhalation anesthetic gas reported recently in medical literature. It is considered to have four times the potency of ether.

It would have been better if your anesthesiologist had taken special training in the usage of Fluothane® and extolled its virtues to the medical staff and then at his request as well as that of the medical staff, would have asked the hospital to provide it. It would likewise be an excellent subject for a medical staff meeting, at which time its usage in contrast to other gases—with all the pros and cons—could be objectively presented.

Do not hesitate to present the anesthesiologist's request and facts to the medical staff and executive committee in order that you may have their guidance and recommendations before fulfilling the request.

* * *

When a patient in a mental hospital has lost his civil rights (committed), does he lose his right to confidential treatment of information?

Morally and ethically, any information on any patient, mental or otherwise, should be kept a privileged communication. It is my understanding that this is also true legally, but to be sure consult your attorney.

* * *

How are we to handle charts of patients who have been in isolation? How are we to sterilize the charts?

The chart for a patient who has been in isolation is handled in the same manner as any other chart. It does not need to be sterilized. The charts for patients in isolation should be kept in the rack at the nurses' station and not in the individual patient's room.

Treat the patient, observe proper isolation technique, and *after* leaving the isolation room, do the necessary charting.

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 200 E. Ohio St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.

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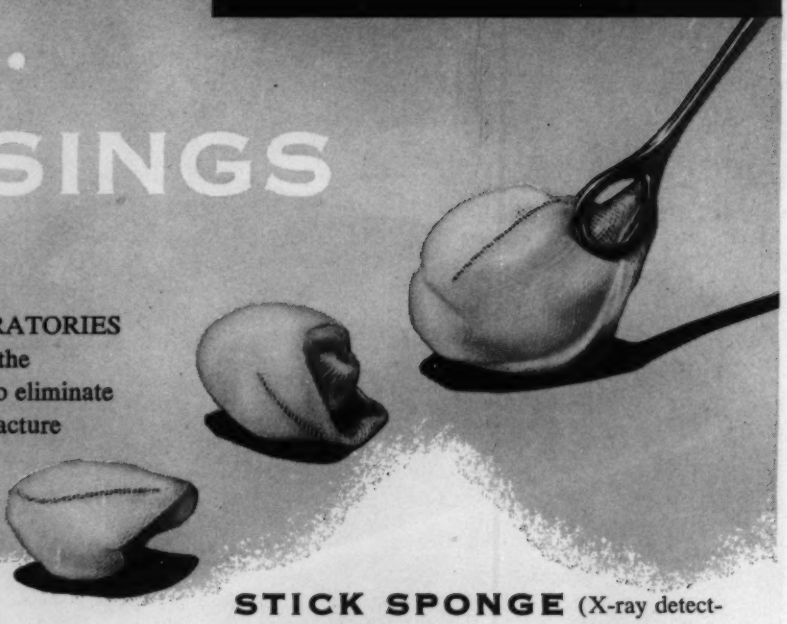

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Aloe recognizes complete acceptance of any Aloe developed unit only after long use in a large cross section of the nation's hospitals. Each unit shown here is now in use in many of the world's leading hospitals, and is fully accepted as equipment designed and built according to the highest standards in the industry.

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All the equipment shown here was originally designed and is manufactured in our own St. Louis factory. Experienced Aloe equipment engineers work closely with hospital authorities to develop specific units or coordinated assemblies to meet the exact requirements of the hospital user.

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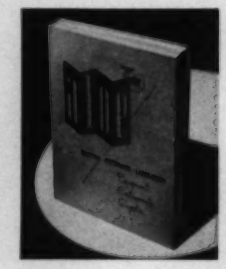
Aloe Equipment Planning Service, staffed by experienced equipment specialists, is prepared to give you expert assistance in equipment layout and selection. Write or see your Aloe Representative for details.



You will find complete specifications of Aloe Nurses Station Equipment in our 804-page General Catalog No. 189. If this world's most complete catalog is not in your files, your Aloe Representative will be happy to supply you with a copy.

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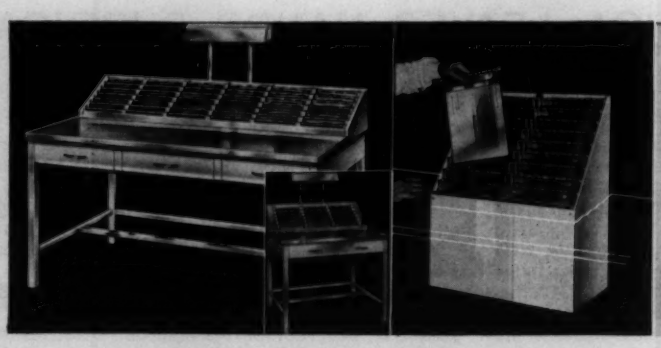
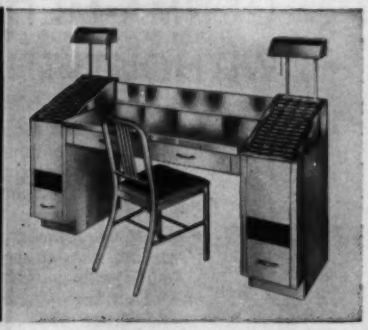


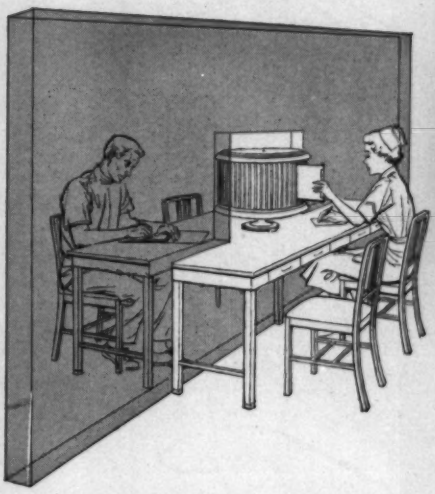
McGregor Chart Desk—20, 30, or 40 chart capacity Midget McGregor (inset)—18 chart capacity.

Chart File—Build in counter, hang on wall, set on table; 10, 20, or 30 chart size.



Suggested assembly of modules: 15-chart units may be assembled in banks.

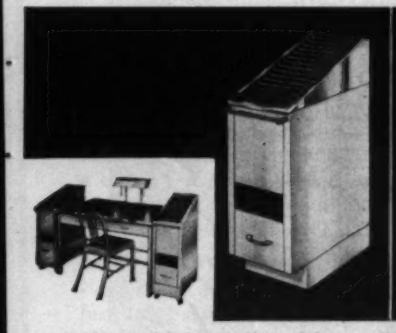
You Have in Mind



Pat. Pending

The Aloe-Exclusive Revolving Chart Holder (at right above) has gained tremendous popularity during the past decade. Reasons are obvious: unequalled convenience in actual use, and great variety of possible arrangements for convenience of access. Arrangement shown above (left) solves a common problem involving free access to the charts by both doctors and nurses without mutual interference. Counter model unit may be placed between areas divided by an actual partition or opposite seating. At right is shown a few of the many other possible arrangements of this versatile unit.

Available in 20, 30 and 40 chart capacities. Mobile unit also available (inset).



Mobile unit used alongside Nurses desk. Easy to modify or expand.

Mobile Chart File with folding work shelf; available 20, 30, or 40 chart capacity.

Alumiline Koenig Dressing Cart carries complete facilities for dressing service.

Alumiline Dispensa-Cart—a complete, one-trip medicine dispensing unit.

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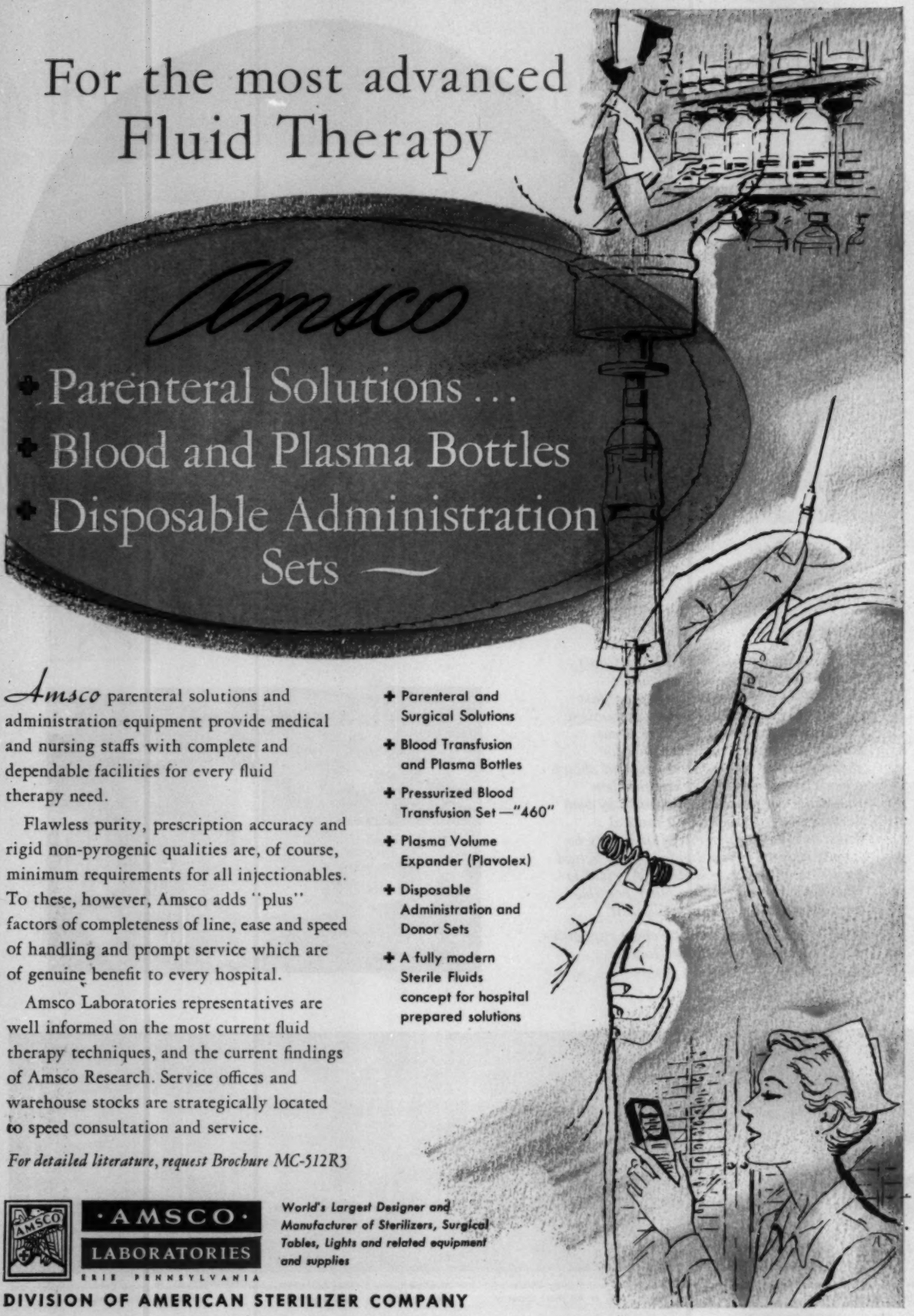

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- Blood and Plasma Bottles
- Disposable Administration Sets —

Amsco parenteral solutions and administration equipment provide medical and nursing staffs with complete and dependable facilities for every fluid therapy need.

Flawless purity, prescription accuracy and rigid non-pyrogenic qualities are, of course, minimum requirements for all injectionables. To these, however, Amsco adds "plus" factors of completeness of line, ease and speed of handling and prompt service which are of genuine benefit to every hospital.

Amsco Laboratories representatives are well informed on the most current fluid therapy techniques, and the current findings of Amsco Research. Service offices and warehouse stocks are strategically located to speed consultation and service.

For detailed literature, request Brochure MC-512R3

- Parenteral and Surgical Solutions
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- Pressurized Blood Transfusion Set—"460"
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It's here—the first basic improvement in design and construction since the inception of metal furniture! *Ventura* . . . a complete line of chests, dressers, and bedside stands that permits you to choose individual panels for every surface, from a broad range of materials and finishes that blend harmoniously with Royal's many different patient beds, overbed tables, chairs and lounges.

Never Before . . . Such Beauty, Flexibility, Versatility

Ventura . . . by Royal gives patient rooms truly custom-made furniture, at production-line prices, with an almost limitless combination of materials and colors. *Tops* include Plastelle-enameled metal, Royaloid over plywood, and solid Fiberesin. *Fronts* may be Plastelle-enameled metal, or solid Fiberesin. (All Fiberesin panels available in warm natural birch, walnut, cherry or butternut finishes.) *Legs:* square-tube steel Plastelle-enameled or satin finish. *Sides and Backs:* Plastelle-enameled metal.

Never Before . . . Such Ease of Maintenance!

Ventura . . . by Royal features quickly replaceable tops, drawer fronts and side panels which attach to sturdy "skyscraper" inner steel frames . . . repair jobs are made right in the room without inconvenience to patients or disruption of normal routine.

We think you'll agree that here—at last—is the last word in modern hospital furniture. Write for specifications, prices and full information on beautiful, colorful *Ventura* . . . *by Royal!*

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PROFESSIONAL DIVISION

staph newsletter

FIFTH OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTION

WHILE this letter is being written, reports are increasing on the occurrence of flu and flu-like illnesses leading rapidly to staphylococcal pneumonia and ending in death. By the time you are reading this, influenza may have become truly epidemic or it may have started a seasonal downtrend. But with its already wide national spread mentioned in USPHS-HEW Morbidity and Mortality Reports as breaking out from Hawaii to British Honduras—we all realize no precautions can be too stringent. Since it is known that influenza virus persists for days in a virulent form in the environment, intensive disinfection is an essential preventive measure.

"Infections have occurred that nothing known to medical science at present time will cure. There is also evidence accumulated to show the same trend in some other bacteria, especially some of the gram-negative bacilli found in the urinary tract. Our problem, though simple, is a big one and we have just begun to fight back. These staphylococcal infections manifest themselves by wound infections, furunculosis, pneumonia and enteritis. The first two are our concern because they are sources of spread of the organisms and the last two are vicious in their assault on human life. The pneumonia and enteritis may kill quickly and surely in one to three days." Arnold W. Lempka, M.D.: Nebraska State Medical Journal, October, 1959.

In the matter of aseptic housekeeping of the operating room, Dr. Lempka recommends that "no dusting should be allowed. A wet scrub or washdown is in order."

Tergisyl®, Lehn and Fink's combined phenolic disinfectant and detergent, is being used widely and effectively for flooding floors and washing down all equipment and surfaces in the operating room. Dr. Ralph Adams, Chief of Surgery at Huggins Hospital, Wolfeboro, N. H., has reported disinfection with Tergisyl as an integral part of his established system for controlling infection in the O.R. The infection rate was reduced from 2% to .25%. If you would like reprints of Dr. Adams' article from the American Journal of Nursing (August, 1959), please let us know.

The importance of "The Committee on Infections" has occasionally been discussed by us on this page, or in other L&F communications to our hospital friends. Generally, we have assumed that you had a committee continually evaluating the staph problem and we have offered any assistance or information you might find useful from our long experience in developing efficient disinfectants for hospital use. In his Hospital Management article on infections committees, Dr. Charles U. Letourneau has some interesting suggestions. As those of us who know Dr. Letourneau would expect, the article pulls no punches and calls a spade a spade but, as we would also expect, the recommendations are well founded and documented. You'll find it on page 37 of the February, 1960, issue.

Successful reduction of staphylococcal infection in a 28-bed male surgical ward at the British Royal Infirmary is reported in The Lancet for November 7, 1959, page 781. Infection rate had been 40% on open wounds, with 3.3% considered significant because of such complications as pneumonia, urinary tract infection, parotitis, enterocolitis, furunculosis, and wound sepsis originating at operation. Introduction of a combination of preventive measures, closely studied for two years, resulted in appreciable reduction in staph infection, not only in the ward but in O.R. infections in patients from the ward. Among precautions followed were: disinfection of blankets and pillows, disinfection of dishes and cutlery, use of germicidal hand cream by nurses, disinfection of the ward barber's shaving brushes and razors, disinfection of bathtubs.

Increased use of the term "contamination control program" by hospitals who have begun by concentrating on staph infection control, brings us again to some other organisms which need control. For instance, the Journal of the American Medical Association (January 23, 1960, page 329) has a detailed report on a case of postoperative endocarditis due to Pseudomonas aeruginosa. In this case, recovery followed reoperation and long convalescence but the source of infection was never determined. Other articles are mentioned reporting similar infections following heart surgery, most of which ended fatally. Bacteremia following cardiac catheterization was reported in the June 4, 1959, issue of the New England Journal of Medicine. Studies of the source revealed that disinfection had been attempted with substances inadequate to kill the virulent, resistant Pseudomonas aeruginosa inside the catheters.

Lehn & Fink synthetic phenolic disinfectants—Amphyl®, O-syl®, and Lysol® disinfectants, and Tergisyl® detergent-disinfectant are all highly efficient against Pseudomonas aeruginosa. In addition to being pseudomonacidal—all Lehn & Fink disinfectants are broad spectrum microbicides which are also staphylocidal, fungicidal and tuberculocidal. Routine decontamination of floors, surfaces, blankets, and linens can be one of the most economic, effective, and simple control measures against superinfection. Here's why—it reduces the number of organisms available for spread by any route—contact, nasal, or airborne—in turn, reducing excess hospital days and thus reducing hospital operating costs.

Would you like to have bacteriological data on any of the Lehn and Fink disinfectants? You may find these data of interest. We shall be glad to send them, along with samples of the products requested. If you have any specific questions on infection control in your particular hospital on which we may help, our research laboratories and technical advisors, and I personally, would like to hear from you at any time.

Charles F. Manz
General Sales Manager
Professional Division

LEHN & FINK PRODUCTS CORPORATION
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LF 9-2269

HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—*the constancy of change*

LESS THAN 100 years ago, before the discovery of asepsis, the scene of a surgical operation was likely to be almost anywhere that was convenient to the surgeon or the patient. Demonstration of a surgical technique often was a feature at gatherings of surgical societies. Operations at this time were made with unwashed hands and instruments that had not been disinfected, with dirty sponges and bandages, and the mortality rate due to sepsis was very high. Even Worrall Mayo, founder of the world famous surgical clinic, for most of his career used a living room table or door taken off its hinges and laid on benches as an operating table.

Such men as Joseph Lister, Ernst von Bergman and William Stewart Halsted not only revolutionized surgical procedures but changed the whole appearance and concept of the surgery room. From virtually a public place it became more and more a guarded sanctuary, with access limited to doctors, nurses, the patient. Observers, who formerly had crowded around the table, were kept at a distance in a gallery.

As surgery slowly extended its range to one organ after the other and into regions of the human body that had seemed inviolate, the operating room and its equipment became more complex, more highly specialized, and access rules more rigid.

Today, surgeries have retreated to the innermost recesses of the hospital, shielded now even from the possible contamination of unfiltered air.

There is no reason to think that the tremendous change in the operating room that has come about during the last century has reached an end. Indeed, as one of the authors in this special issue observes, even the best planned operating suites of today are still far from ideal in some respects. That the search for the ideal operating suite in terms of plan, materials and physical equipment continues unabated is apparent in the compilation of trends in surgical suite design to which this issue is devoted.

—*'payola' for hospitals*

RECENTLY, ACROSS the desk of the administrator at ———— Hospital came two invitations. One stated, in part:

> "I've Christmas gifts by the score this year and one with your name on it.
>
> "Here's all you do—just send in your order for ———— or for ———— and your choice of a Nationally Advertised gift will be sent immediately to you."

The gift brochure shows a beaming Santa, whose face is probably well known in maintenance supply circles, seconded by a smiling Miss Jingle-Bell who suggests that "I'd just love to put a present under your Christmas Tree just for you."

The second invitation announces:

> "We take pride in sending you this new Double Bonus premium sheet—for it is just what we call it!
>
> "This is a standing offer to allow you to select premiums over and over again as you place your orders."

These gifts and premiums would certainly be useful to the hospital. They include an electric train, a bicycle, wristwatches, shotguns, golf clubs, outboard motors and other helpful appliances.

These beneficial plans work on the point system. One point is given for the purchase of a 55-gallon drum of any ———— or ———— product. The purchasing agent gets one point for each drum purchased. As Miss Jingle-Bell says, "It's so easy—and free."

It even beats trading stamps. The purchasing agent does not need to lick bad-tasting stamps and paste them in books. He does not need to wait in line and then lug an unwieldy television set home in the car. He only has to call the supplier collect and his premium or bonus will be delivered to his home. Some suppliers will keep track of his points.

Consider the following figures to learn how a hospital would be affected financially if the purchasing agent decided to take advantage of these bonus and gift plans.

A good all-purpose cleaner commands a current market price of approximately $2 per gallon. The bonus and gift suppliers list their all-purpose cleaners at $2.50 per gallon. This means that the hospital overpays $27.50 per drum if it buys their products. In exchange for this overpayment, the purchasing agent gets a personal gift worth approximately $15.

The kindest adjective one could use for purchasing agents who indulge in such practices is "naive." One could think of harsher ones without any trouble.

The 1960 planning and construction issue

THE SURGICAL SUITE

HOSPITALS, J.A.H.A.

IN THIS operating room, electrical circuit controls, ground detector, electric clock and anesthetizing location receptacles are located in the corner box behind the surgical team. For the photograph, the table has been reversed; normally the surgeon and anesthetist face the corner cabinet. Sheet vinyl covers the walls.

Evolution of the surgical suite

by ROY HUDENBURG

The surgical suite of the 1960's has evolved from a single corridor unit to a broadened area allowing for central work space, the author asserts. He describes today's emerging operating suite as being located adjacent to the emergency and x-ray services on the ground floor or basement level; its features include a central clean core with a peripheral corridor for tight traffic control, waiting facilities for outpatients, and x-ray view boxes.

SINCE 1919, the surgical suite has moved from the hospital's attic to its cellar and fattened in the process. The surgical suite of the 1960's has evolved from considerations of asepsis and efficient work production, improved lighting equipment and air conditioning. Some elements of design have been influenced by the introduction of the anesthesia machine for the administration of gas-oxygen mixtures.

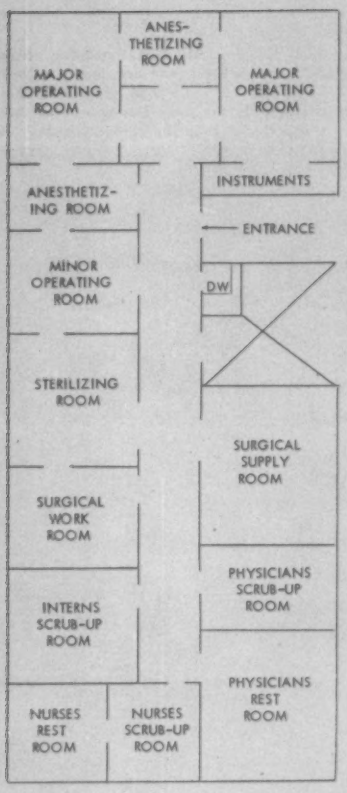
While today's emerging surgical suite is the principal theme of this discussion, its departures from traditional concepts can best be seen when contrasted against earlier designs.

Hospitals as we know them owe much to the collaborative work of Asa Bacon, M.D., and Perry Swern, architect. Figure 1 shows the surgical suite they laid out for a 160-bed city hospital, as printed in their privately published *Efficient Hospitals.* [1]

In 1919, the surgical suite was located on the top floor of the hospital; since adequate surgical lighting was still lacking, the north-oriented large windows of the major operating rooms were needed to admit maximum daylight.

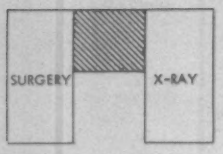
It is interesting to note that at

TO PROVIDE daylight needed for adequate surgical illumination, the 1919 operating suite was located on the top floor of the hospital. This schematic drawing was designed for a 160-bed city hospital.



1919
SURGICAL SUITE

ASA BACON
PLUS
PERRY SWERN
ARCHITECT



TOP FLOOR OF HOSPITAL

that time, because of the prevalent distribution of patients by medical services and relatively long surgical stays, two major operating rooms were considered ample for a 160-bed hospital. Without regard for floor contamination, personnel could reach their dressing rooms only by entering the suite near the operating rooms and traversing a long corridor past workrooms and sterilizing rooms.

NEW CIRCUMSTANCES=NEW LAYOUT

When in 1946 the late Marshall Shaffer of the United States Public Health Service, with his staff, developed the general hospital prototypes in "Elements of the General Hospital,"[2] a new set of circumstances governed their location and layout. (Figure 2.)

Good surgical lighting had become available; since daylight was no longer required in the operating rooms, the surgical suite could be moved from the top floor. In smaller hospitals the suite tended to be located in the stem of a "T" and, depending on circumstances, on the second or third floor, where it usually adjoined surgical beds. At this stage the surgical wing had not fattened out; building widths were usually restricted to single corridor design, since there was still little dependence on mechanical ventilation and air conditioning.

However, there was concern with dirt being carried on the shoes of personnel into operating rooms; for this reason the operating rooms were placed at the end of the corridor and personnel dressing rooms closer to the entrance from the hospital corridor. In this plan, the anesthetizing room had been replaced by a substerilizing room with its duplication of sterilizing equipment. The central sterile supply room had made its appearance, but was linked organizationally to the surgical suite. The recovery room was in limited use so that it did not appear in the prototype suites until later. The fracture room and cystoscopy room adjoined the surgical suite but were divorced from the x-ray department, which, because of functional limitations, had to be located elsewhere.

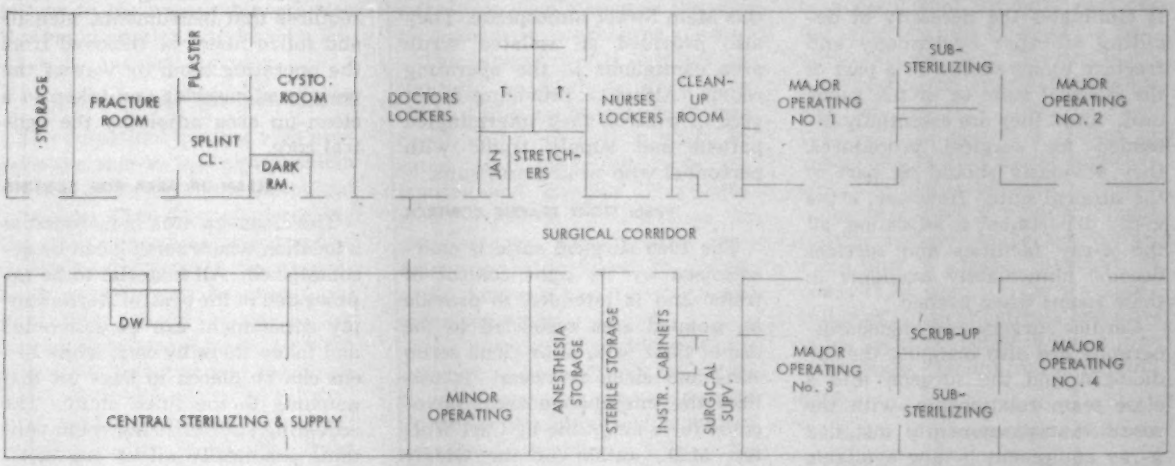
SUITE SCHEME IN 1960

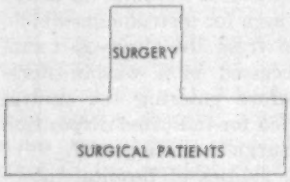
Figure 3 shows schematically the shape of the new surgical suite as it appears to be developing in 1960 and as it is taking shape in a number of new hospitals.

The first thing to note is that it has been freed of the restricting envelope of a single corridor unit, so that it has broadened out to accommodate central work space. In order to fit the broader suite into the hospital building, it is frequently advisable to locate it on the ground floor or in the basement of the new hospital. With air conditioning, good ventilation, adequate lighting and adequate elevators, basement locations are quite satisfactory.

The present-day interplay between the surgical suite, the emergency suite and the x-ray department is such that the three units seek adjacent locations on lower floors. One of the principal factors governing this interrelationship is the growing concern among surgeons with the results of hasty suturing performed in emergency suites. There is a definite feeling that any facial or scalp suturing, any repairing of damage to the hands, and even minor surgical procedures, should be done in the surgical suite where there are trained personnel, a ready selection of instruments and aseptic conditions. Work in the emergency department tends to be limited to first aid, diagnosis, and the care of medical emergencies. The general philosophy is that if the emergency service and surgical suite are contiguous or conveniently close, there will be reduced resistance to moving emergency patients into the surgery department.

Reasons for the inclusion of the x-ray department in this tripartite

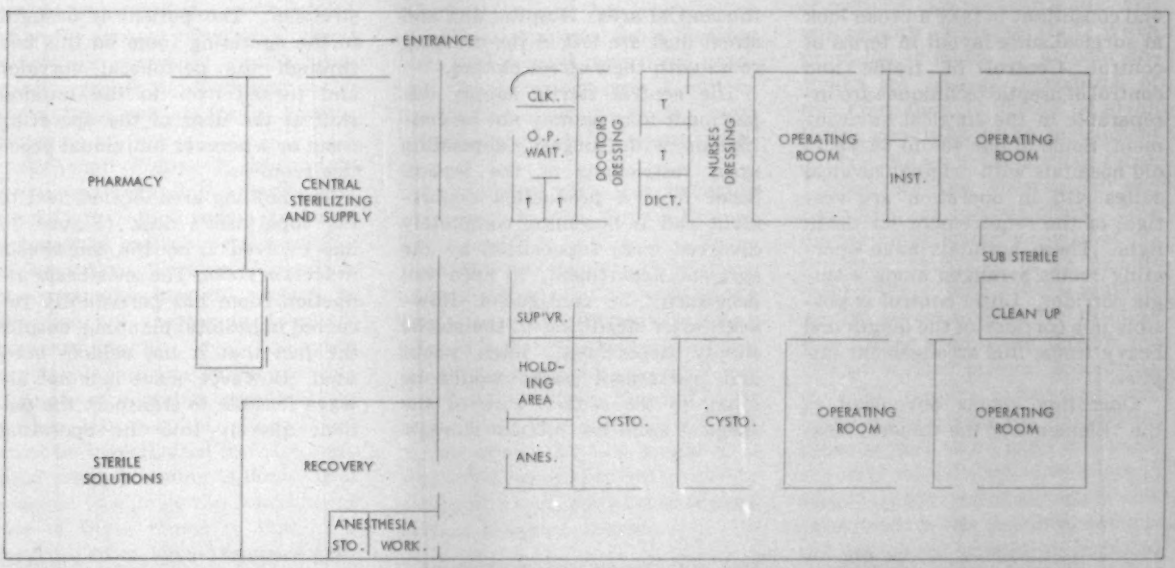


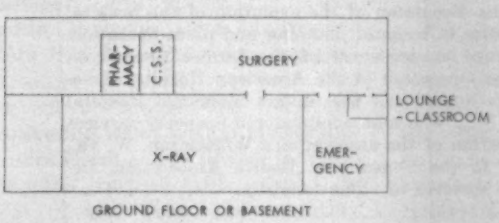


IN THIS 1946 schematic drawing by Marshall Shaffer and his staff at the U.S. Public Health Service, satisfactory artificial lighting resulted in a second or third floor location. Concern with contaminated shoes brought about a changed layout for the operating suite.

1946
U.S.P.H.S. SURGICAL SUITE

MARSHALL SHAFFER
ARCHITECT





THIS SCHEMATIC representation of a surgical suite was developed by the author as hospital consultant with Smith, Hinchman and Grylls, a Detroit architectural firm, for an addition to Metropolitan Hospital, Detroit.

1960
SURGICAL SUITE

complex are fairly well understood. It eliminates the necessity of deciding whether cystoscopy and fracture rooms should be a part of the surgical suite or of the x-ray unit. Since they are essentially intended for surgical procedures, they obviously should be part of the surgical suite. However, if the x-ray department is adjoining, all the x-ray facilities and services become immediately available in these rooms when needed.

Cardiac surgery and angiocardiography are also bringing the radiologist and the surgeon into a close team relationship, with the result that permanently installed x-ray equipment is now available for installation in operating rooms. Thus, surgery and x-ray are becoming functionally interrelated to a point that their architectural interrelationship is almost a corollary. Since surgery and x-ray departments gravitate toward the emergency unit and all three require sizable space easily accessible to an emergency entrance at or below grade, they inescapably are bound to the ground floor or the basement.

The release from restraining influences has allowed the architect and consultant to take a broad look at surgical suite layout in terms of control. Control of traffic and control of aseptic techniques are inseparable in the surgical environment. Some of our 40- to 50-year-old hospitals with original surgical suites still in operation are vestiges of the requirement for north light. These hospitals have operating rooms arranged along a single corridor. Little control is possible in a corridor of the length and heavy traffic this arrangement implies.

Operating rooms developed in the "Elements of the General Hospital"[2] were better protected from this Main Street atmosphere. They also provided an isolated scrub area contiguous to the operating rooms. Although providing a degree of control, they intermingled patient and supply traffic with personnel who wear scrub suits.

1960: TIGHT TRAFFIC CONTROL

The 1960 surgical suite is characterized by its tight control of traffic and is intended to provide an isolated area restricted to the use of those who wear clean scrub suits and clean footwear. It utilizes the interchange areas advocated for a long time by Carl Walter, M.D., author of the widely accepted text, *The Aseptic Treatment of Wounds*.[3]

Examination of Figure 3 shows a central core, the essentially clean area. It also shows a peripheral corridor which is used for all traffic prohibited from the clean area. The plan provides doctors and nurses dressing rooms, which, properly used, require the surgeons and the nursing personnel to enter their dressing rooms via the peripheral corridor. There they dress in clean scrub suits and prescribed footwear prior to entering the central area. Hospital dirt and street dust are left in the dressing room with their street clothes.

The central sterile supply department may or may not be contiguous with surgery, depending upon restrictions of the layout. Since it is a production department and is becoming completely divorced from supervision by the surgical department, it need not necessarily be contiguous. However, after sterilizing in the sterile supply department, linen packs and instrument packs would be taken to the central core of the surgical suite for interim storage.

Proper functioning of the suite requires that instruments, utensils and soiled linens be removed from the operating room by way of the peripheral corridor and taken to a clean-up area adjoining the central core.

CLEAN-UP AREA FOR SORTING

The clean-up area is intended as a location where sorting can be accomplished. All material to be reprocessed in the central sterile supply department can be assembled and taken there by cart, while linens can be placed in bags for dispatching to the linen chute. The adjoining substerilizing room contains practically all of the sterilizing equipment needed for the suite. This area becomes an interchange area for instruments which, received from the clean-up room, are processed in a washer-sterilizer before entering the central work area for indicated disposition by the surgical nursing staff.

Since studies of hospital infection indicate that hospital room bed linen should not be brought to the surgery suite, the growing preference in transporting patients is the recovery room bed, which is essentially a combination bed-stretcher. The patient is brought to the operating room on this bed through the peripheral corridor and turned over to the nursing staff at the door of the operating room or wherever individual practice requires.

The holding area located next to the supervisor's desk (Figure 3) has evolved from the anesthesia induction room. The anesthesia induction room has persistently recurred in hospital planning, despite the fact that it has seldom been used. However, since it is not always feasible to transport the patient directly into the operating

the author

Roy Hudenburg brings to his discussion of the evolution of the hospital surgical suite broad experience in hospital planning and plant operation. From 1945 to 1952 he served as secretary of the former Council on Hospital Planning and Plant Operation of the American Hospital Association. He left the Association to join the Miners Memorial Hospital Association in Washington, D.C., where he administered property services and the physical plant operation of the association's Williamson, W. Va., hospital. In 1957 he went to the Community Health Association, Detroit, and now serves as its director of clinic facilities.

room, the holding area is a humane answer to the regrettable practice of allowing patients to lie on a litter in the surgical corridor.

WAITING AREA FOR OUTPATIENTS

The outpatient waiting area provides the answer to a new problem —what to do with the ambulant patient in these days of increasing hospital-centered medical practice. Following the trend to move emergency surgery into its proper environment, many surgeons are moving ambulant surgery from the outpatient department or the emergency treatment service to the surgical suite.

However, the outpatient must have a dressing room in which to remove his clothing and put on a clean gown and some place to wait until it is time for him to be escorted to the operating room. The ambulant patient waiting area with several dressing rooms provides the answer; it is located close to the surgical clerk's desk for convenience of supervision.

The surgical clerk provides the same basic type of services for surgery and the surgical supervisor as the ward clerk provides for bed areas. The clerk's desk, of course, should be located at a critical point of traffic control since the surgical supervisor obviously cannot carry out her proper functions and at the same time act as traffic control officer.

Although Figure 3 shows two cystoscopic examining rooms, the need for two such rooms would be determined entirely by the volume of urological work performed in the particular hospital. Again, in the light of increasing hospital-centered practice, some urologists are developing a preference for doing all cystoscopic examinations within the hospital. This trend must be investigated for each hospital when planning is done. It is feasible to change the functions of one of these rooms to that of a fracture room, since the space presumably will adjoin the x-ray suite. However, some administrators question whether a separate fracture room is required. One school of thought provides one operating room with a connecting splint closet and an alcove for storing the fracture table when it is out of use. Thus, one operating room can be quickly transformed to a fracture room whenever the need for orthopedic procedures arises.

The central core is outfitted essentially as a clean work area, clean utility room and scrub area. Scrub sinks are appropriately located near operating room entrances and guarded, if desired, from surrounding activities by glass screens. Pass-through cabinets may be installed in storage walls between the core and the operating room.

The elimination of the substerilizing room in hospitals with four or more operating rooms will tend to reduce the required amount of installed equipment. The autoclaves in the single substerilizing room shown in the 1960 hospital suite should be adjustable for use either as instrument washer-sterilizers or rapid instrument sterilizers. With more than four operating rooms it may be necessary to locate one such autoclave in the central core. Somewhere in this work area there will also probably be provision for a small gas sterilizer to handle cystoscopic and other optical instruments. Equipment in the central core will also include storage cabinets for sterile fluids. Whether or not the cabinets for sterile water will have heating coils will depend upon local practice. In some instances it will be found that surgeons prefer room temperature water to warmed water.

The central core was probably pioneered in the Kaiser-Permanente hospitals built in San Francisco and Los Angeles. Variations of this theme may be seen in the Chuquicamata Hospital being erected in Chile.[4] Another variation which preserves the general theme is in the Holy Cross Hospital being built in San Fernando, Calif.[5] The design shown in this article is a simplified representation of a suite designed for an addition to Metropolitan Hospital, Detroit.

RECOVERY ROOM: AN INTEGRAL UNIT

The recovery room appears for the present to be an established component of the surgical suite. There is no present indication that the establishment of acute nursing units will generally involve functions related to reaction from general anesthetics. This phase of recovery involves the anesthetist to a point that logically requires the recovery unit to remain a part of the surgical suite. The best planning places the anesthetist's office and the recovery room in close proximity to permit a degree of visual observation by the anesthetist. The highly portable recovery room bed with a manual height control appears to be the equipment now in greatest demand. It tends to be used for the transportation of surgical patients and provides relative comfort when patients must remain in the holding area.

OPERATING ROOM SIZE

Operating rooms in general seem to be fairly well stabilized as to layout. "Elements of the General Hospital"[2] indicate operating room sizes of approximately 18 feet by 18 feet or 16½ feet by 20 feet. There are, however, indications that in hospitals of 200 or more beds, consideration should be given to the provision of at least one larger room. Such a room might measure at least 20 feet by 20 feet. The thought behind this recommendation is that an increasing number of complicated operations can be anticipated and will require additional staff. When provision is made for a room designed for special procedures of this kind, thought should be given to the provision of an instrument gallery and an x-ray control room.

Need for the observation and recording of physiological data during complicated surgery is increasing. Provision of an instrument gallery with a view window should be considered for meeting this future need, even though the present level of surgical procedures may not require instrumentation. Until nonflammable anesthetic gases become more generally used, the expense of explosion-proofing electrical equipment generally dictates that, when possible, electrical equipment should be installed outside of the anesthetizing location.

Equipping the surgery department with a permanently installed x-ray machine that operates on a ceiling track is now entirely feasible, for such apparatus is available. The demand for x-ray plates of increasingly high quality indicates

that the planning of new surgeries should provide for future installation of such equipment. However, technical problems, again involving the need for coping with complications in the use of flammable anesthetics, make it desirable that the x-ray controls be located outside of the anesthetizing location. This implies the establishment of an x-ray control gallery with visual observation of the surgical table.

POWERFUL WIRING DEMANDS

As an aside on the question of x-ray in operating rooms, special attention should be paid to adequate wiring for the more powerful portable x-ray machines now available. The power demands of a 300 milliampere mobile x-ray unit are such that it becomes desirable to separate branch circuits. Circuits serving receptacles which are intended to power mobile x-ray units should be separated from the ungrounded electrical systems serving the balance of the anesthetizing locations. Such x-ray outlets may be connected by a subfeeder to a separate isolating transformer.

Another recommendation of Dr. Carl Walter is the so-called corner cabinet, which is currently seeing greater acceptance in operating rooms. This cabinet, located in the "dead corner" of the operating room, is usually designed to provide for the centralization of the electrical system serving the room. Ideally, it contains the isolating transformer required for the ungrounded circuits in the room. It also contains all the necessary anesthetizing location receptacles and the required circuit breakers for the various branch circuits which serve both those receptacles and the surgical lighting in the room. Where intercommunication is to be established with the supply center, the supervisor's or clerk's desk, or in some cases with the office of the pathologist, the intercommunication system speakers may be located in this corner cabinet. Below the five-foot level this cabinet is frequently devoted to a shelf containing suction bottles and piped suction and oxygen outlets.

Originally, x-ray view boxes were also included in this corner cabinet design, but experience with the use of the view box in the dead corner has brought about a preference for locating the view box near the peripheral operating room door. This permits the x-ray technician to deliver x-rays easily to the point of use without actually walking into the operating room.

Operating room ventilation remains a controversial subject. This is despite the statement of the National Fire Protection Association Committee on Hospital Operating Rooms that recirculation of air in ventilating systems which serve anesthetizing locations does not increase the hazards of fire and explosions from flammable anesthetic vapors. The need for an air supply that is relatively free from bacteria is recognized. It is still necessary to weigh the cost of installing highly efficient air filtering systems against the cost of exhausting to the atmosphere all of the air that has been heated or cooled and replacing it with fresh air that in turn must be completely heated or cooled. In any event, complete air conditioning is now a requirement since the "Code for Use of Flammable Anesthetics" requires the maintenance of relative humidity at not less than 50 per cent.

DESIGN OF VENTILATING SYSTEM

A surgical suite as shown in Figure 3 calls for a ventilating system that will maintain slightly positive pressures at both the central core and the anesthetizing locations. The pressure should be designed to assure that air movement from all such areas will be toward the peripheral corridor. To make the system of aseptic environmental controls work properly, surgical personnel should acquire the habit of latching the operating room doors to the peripheral corridor; this will prevent unauthorized entrance from the corridor. At all times during surgery, the door to the central core should remain closed. Proper hardware design will assist in achieving these ends.

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Author's note: Some of the conclusions reported in this article may have been influenced by criticisms of surgeries contained in an article by A. N. Kiff and M. Worthen in the September, 1958 *Architectural Record*, cited above, which specifically quotes W. H. Potter, M.D., chief of surgical service, Harlan Memorial Hospital, Harlan, Kentucky; John D. Thompson, research associate, Hospital Administration Section, Yale University School of Medicine; and James J. Souder, A.I.A., Kiff, Colean, Voss & Souder, New York City.

EMERGING FROM RESEARCH—A PORTABLE 'HEART'

To help save the lives of victims of acute heart attacks, research is now developing a portable heart machine which can be rushed quickly to the scene. At present, use of these machines is restricted to hospital surgery rooms. The research is part of a study on mechanical assistance in acute heart failure being made by John Connolly, M.D., of the Stanford Medical Center, Palo Alto, Calif. The study, now in its second year, is financed by a U.S. Public Health Service grant.

A portable "bypass kit", already developed in the study, consists of tubing and a pump. An offshoot of present surgical heart pumping mechanisms, this machine relieves the heart of part of its load by drawing blood from veins, returning it to the heart and pumping it into arteries. Dr. Connolly also hopes to create a more complex portable heart-lung machine which can oxygenate blood as well as pump it.

At present, there are obstacles to the quick application of either machine. They require a team of medical technicians and large amounts of blood, which are now impossible to activate on short notice. ■

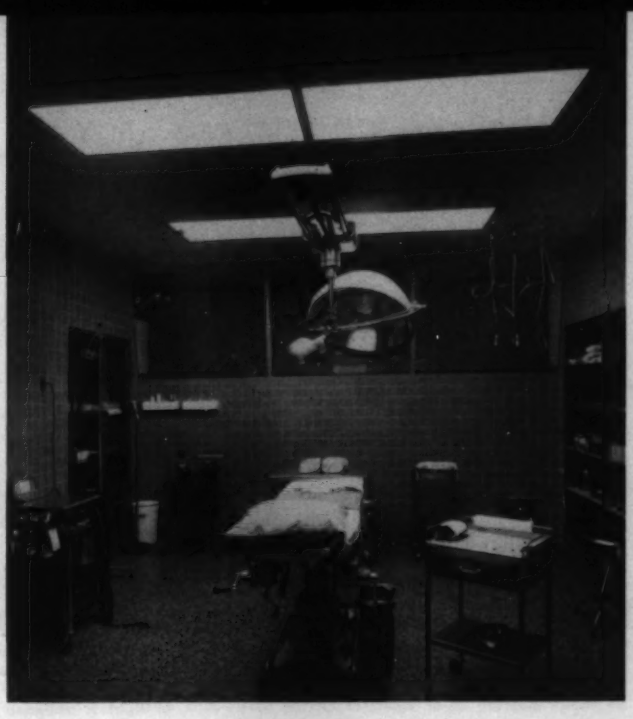
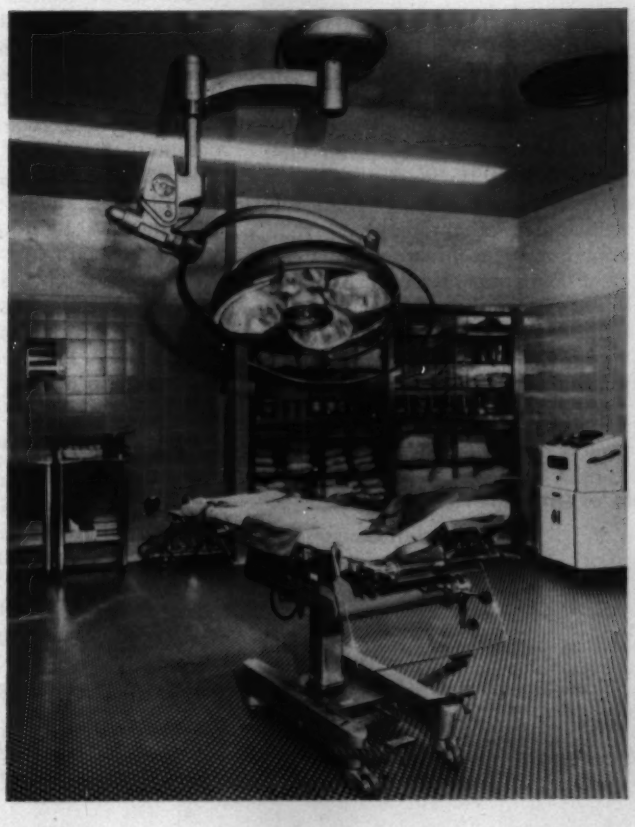


FIG. 1—General lighting for this operating room is provided by a recessed diffusing panel of fluorescent lighting units. The operating light is a ceiling-mounted adjustable unit with a two-filament lamp.

SOLVING THE PROBLEM OF SURGICAL LIGHTING

by C. L. CROUCH and J. E. KAUFMAN



Satisfactory surgery room lighting requires bright light at the operating point and lighted but nonglaring surroundings, the author states. In addition to describing current research on lighting, he discusses the illumination requirements for the surgical suite, including the light reflectances of room finishes, recommended levels of illumination and necessary equipment.

THE SKILL of the surgeon's hands depends on how well he sees; how well he sees depends upon how effectively the light present reveals the extremely fine detail and poor contrast of the detail against its background. To appreciate this, one can compare the seeing of the outline of buildings in twilight with the ability to see the structure of a blade of grass in full light of day. The contrast in the wound area demands the best that even daylight levels can give. The success of an operation, with its life and death potentialities, de-

FIG. 2—Special lighting is furnished here by a multi-beam ceiling-mounted adjustable light. The recessed fluorescent lighting units provide general lighting.

pends upon the lighting system delivering the light necessary for quick accurate seeing.

Not only must there be sufficient light at the wound; there must be lighted surroundings to preserve the full ability to see the work at hand. Bright light at the operating point with dark surroundings produce glare and depression of vision. Overly bright surroundings are equally bad. There must be a balance with not too great a difference between the surrounding walls, floor and ceiling and the point of operation.

FIG. 3—These unusual ceiling lights are recessed nonadjustable multilamp units with directional lenses. This type of light is designed for low ceilings or for large-area lighting.

BASIC RECOMMENDATIONS

To provide good brightness relationships, room finishes and equipment should have reflectances (reflection factors) approximately as follows:

1. Ceiling (off-white) 80 per cent.
2. Walls (light color, such as blue-green) 60 per cent (nonglossy).
3. Floor (conductive, darker color) 8 to 40 per cent.
4. Gowns and surgical draping (colored, usually blue-green) 30 per cent.

Recommended levels of illumination for quick accurate seeing in various areas of the operating suite are shown in the box below. These values are taken from the *IES Lighting Handbook,* 3rd Edition (1959), and represent the minimum illumination required on the task at any time in the particular location.

In the operating room, the task location may range from the surface of an incision to the bottom of a small narrow cavity. In either situation there should be adequate illumination at the work point. Light directed from wide angles as well as from overhead is often needed to penetrate the wound. Light should also reach the operating area from wide angles to prevent objectionable shadows caused by the surgeon's head, hands and instruments.

SPECIAL OPERATING LIGHTING

Generally, the special operating lighting should be provided by a large area source or a multibeam source; this should direct a minimum of 2500 footcandles to the center of a 10-inch diameter circular area at the operating point and should provide less than 500 footcandles at the edge of that area. For the comfort and efficiency of the surgical team, care should be taken to minimize heat from the lighting systems. This may be done, for example, by using heat absorbing (color-corrected) glass covers to filter out some of the heat-generating infrared energy from the light.

A level of 100 footcandles is recommended as the general lighting level in the operating room to "balance" with the higher level at the point of surgery. This balance is needed to prevent excessive brightness differences between the surgical field and other locations in the room. The present trend in design is to treat all operating rooms in the operating suite as major operating rooms; this gives maximum flexibility.

Anesthesia, preparation and recovery rooms should be provided with indirect lighting. The light produced should be of a color which will enable the medical and nursing staff to observe a patient's condition by evaluating the change in skin color. If fluorescent lamps are used, the deluxe type is preferred.

TECHNIQUES AND EQUIPMENT

All lighting equipment in the operating room should comply with the appropriate code.* The space between the floor and five feet above it is defined as Class I, Group C (hazardous location) and requires the use of explosion-proof equipment.

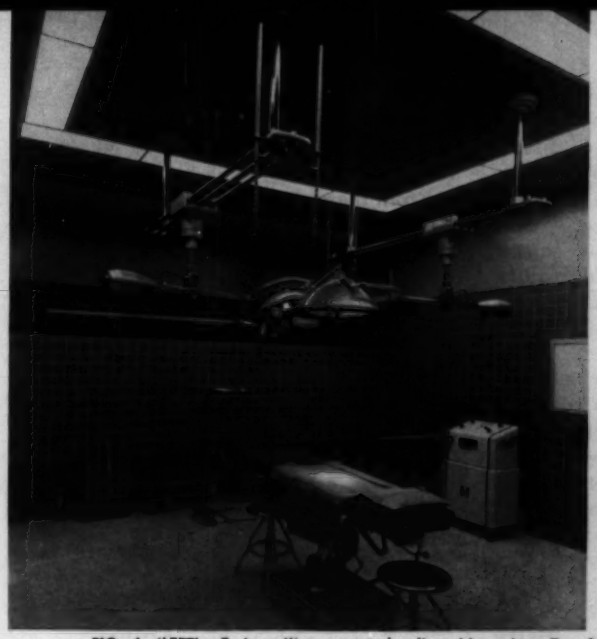
The general lighting in the oper-

Recommended Levels of Illumination

AREA	FOOTCANDLES*
Instrument and sterile supply room	30
Clean-up room (instruments)	100
Scrub-up room	30
Operating room, general	100
Operating table	2500
Recovery room	30

*A footcandle is the amount of light on a surface one foot from a standard candle.

*These are NFPA Code No. 56, "Code for Use of Flammable Anesthetics" and NFPA Code No. 70, "National Electrical Code," National Fire Protection Association.



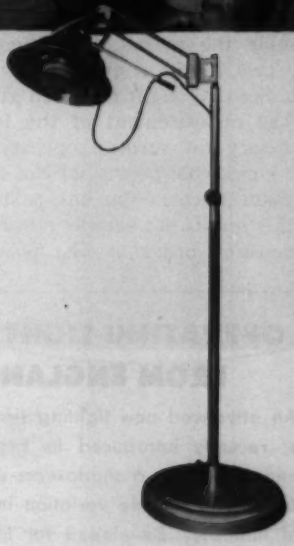


FIG. 4, (LEFT)—Twin ceiling-mounted adjustable units offer the surgeon 2500 footcandles of light over the operating table. The rectangular arrangement of recessed fluorescent units gives general room lighting. (FIG. 5, RIGHT) Lighting for special surgery is achieved by use of this ceiling-mounted adjustable twin lamp unit. (FIG. 6, INSET) Single lamp portable spotlights of this type are sometimes used for increased flexibility. The light is explosion-proof.

ating room is usually provided by recessed lighting units equipped with glass or plastic and ribbed or prismatic diffusing covers (see Figs. 1 and 2, p. 55).

The special operating lighting is usually provided by light assemblies consisting of one or more units (see Figs. 1-5). If only a single unit is used, it should be equipped with a two-filament lamp designed to protect against total lamp failure. Focusing mechanisms built into some lighting units concentrate the light into a beam to achieve the higher levels needed. Many lighting assemblies are adjustable so that the direction of the beam may be changed by moving the luminaire, even during an operation. Other lighting systems can achieve this change in beam direction by switching different elements of systems "on" and "off" (Fig. 3 shows a nonadjustable recessed system.) For greater flexibility, an explosion-proof portable spotlight, as shown in Figure 6, has been used upon occasion.

EUROPEAN TECHNIQUES

In addition to the ceiling-mounted adjustable operating lights and the recessed nonadjustable units previously discussed, some European hospitals have employed other techniques for lighting operating rooms. One hospital in Sweden has 60 spotlight-type lighting units installed in a dome-shaped ceiling in the central part of the room. Each unit is aimed at the operating table. Most of the units are fixed with their beams converging at one point on the table—the center of a sphere-shaped dome. A small group of units can have their beam directions changed remotely to cover any part of the operating table. The units are operated in groups to provide light at the table from the desired direction, overhead or from wide angles. This system has been designed particularly to facilitate viewing for the students.

A hospital in France uses an egg-shaped plaster dome with heat-absorbing glass "portholes." Mirrored reflector spotlight units behind the "portholes" provide lighting for the operating table in a manner similar to the installation in Sweden.

Another special installation uses

the author

C. L. Crouch, technical director of the Illuminating Engineering Society, New York, and his assistant, J. E. Kaufman, pool their recommendations for improving lighting in hospital surgical suites. In his 16-year association with the Society, Mr. Crouch has served as consultant to and coordinator of more than 80 technical committees as well as the Society's liaison with other professional organizations. In addition, Mr. Crouch has spent 15 years as secretary and technical advisor to the Illuminating Engineering Research Institute, which sponsors fundamental research on illuminating engineering at a series of colleges and universities.

a polished metal ellipsoidal-shaped ceiling. The lighting unit (spotlight type) is located at one focus of the ellipsoid and the patient at the other. Training the lighting unit at any part of the ceiling provides light at the same operating point, but from a different angle.

RESEARCH PROMISES BETTER SEEING

Studies are being made at Ohio State University on how to find the light necessary to see all sorts of tasks. Already it has been found that work having poor contrast requires hundreds and even thousands of footcandles for quick accurate seeing. An instrument known as a "Visual Task Evaluator" has been developed that will provide the means of evaluating any task found in everyday practice. Some thought has been given to the measurement of the light necessary for surgical operations; it is hoped that provisions can soon be made to carry this out. A study of this sort is not simple, however, because in order to best portray the details involved it needs to be tied in with a variation of distribution of light toward the wound. Different wounds require different distributions of light.

Studies in England have shown that eyes of older people require more light than eyes of the young adult. Work is being done by H. R. Blackwell, M.D., and associates at Ohio State University to find just how much more light is required by older eyes and by subnormal eyes. The older surgeon with greater skill and experience needs much more light for seeing, according to present indications.

A study is being made at the University of Texas on the role of color in making interiors more interesting and livable. Harry Helson, M.D., has accumulated 150,000 measurements of color preferences with five men and five women as observers. Already the findings appear to indicate preferred color combinations for interiors of both living and working areas. Studies of glare are being carried on at Cornell University and also at the University of Rochester.

From these studies, we may well be on the verge of even better design for the lighting of the hospital operating suite. ■

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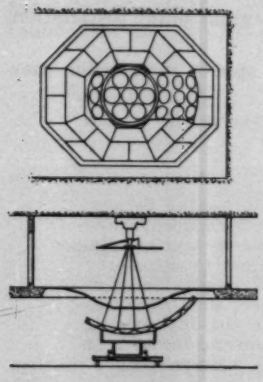
OPERATING LIGHT INNOVATIONS FROM ENGLAND AND FRANCE

An advanced new lighting system for operating theaters, recently introduced in England, features efficient lighting in depth, a shadowless effect, easy use and adjustment and a wide variation in the degree of surface light intensity. Developed for the Maida Vale Hospital in London by Jean Blin of Paris, the new system is described in the January 1960 issue of *The Hospital*, Official Organ of the Institute of Hospital Administrators.

The installation, called a "Bande Tournante," is contained in a room above the theater. The light comes from 19 projectors mounted in a curved steel frame. The projectors throw light through a glass ceiling of "Double Rolled Cathedral" glass. This system can rotate through 360 degrees and move clockwise and counterclockwise. It can also traverse backward and forward to move the light concentration along the operating table. This movement of equipment and lighting is remotely controlled by pushbuttons located just outside the operating theater. The pushbuttons work through relays situated in the room above the theater. A dimmer control can alter the light intensity to meet the surgeon's needs.



Plan and elevation of installation

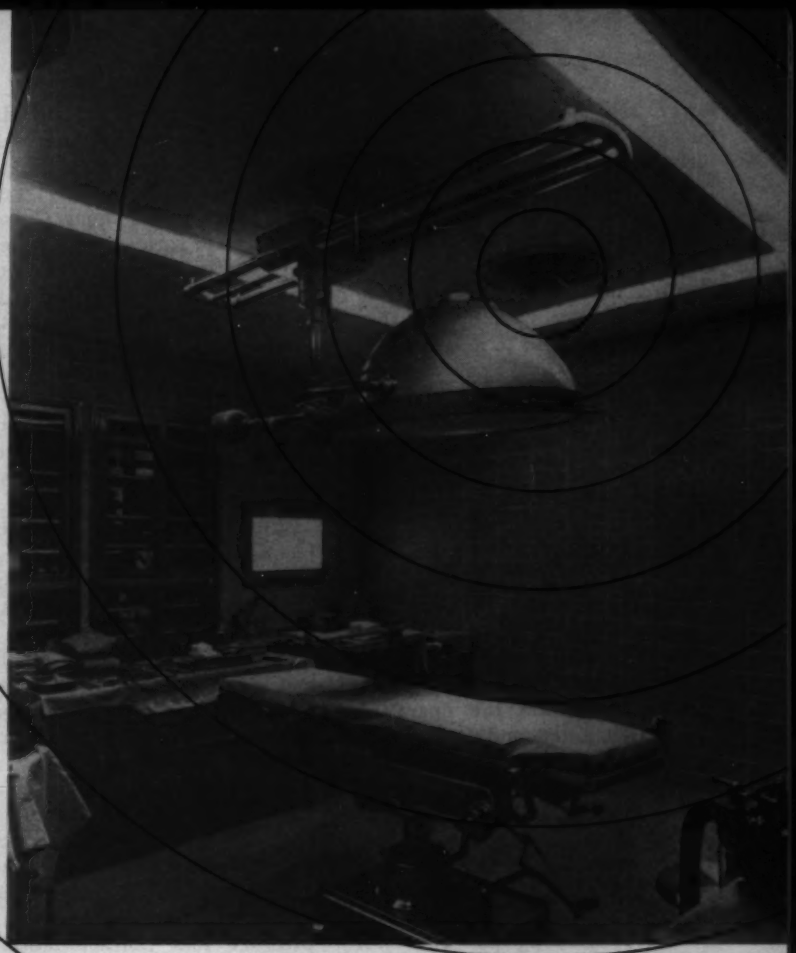
(Drawing reproduced through courtesy of *The Hospital*, official Organ of the Institute of Hospital Administrators.)

A group of nine projectors simultaneously switched on gives a shadowless cone of light converging on the operating field. This group can be selected from any part of the curved band of 19 projectors, thus varying the slope of the axis of the light cone according to the needs of the operation. Groups of 9, 12, 16 or 19 projectors can be used together. The light's frame rotates around a vertical axis, so the cone of light can be adjusted to any direction or slope required.

The disadvantages of heat and dust over the surgeon's head are completely eliminated by this new type of lighting. Also, operations never need to be stopped for moving the light, and valuable operating room space is not taken by the installation.

Providing sufficient light for operations without the heating effect of powerful lamps in the operating theater is being done in France by a system devised by Andre Walter. This is described in a recent issue of *Hospital and Nursing Home Management*.

The light comes from a projector, placed outside the operating theater, which shines through a window in the theater wall onto an elliptical ceiling. This ceiling, arched and covered with polished stainless steel, reflects the light and concentrates it on the small area in which the surgeon is working. Since the light comes from the whole ceiling, shadows are completely avoided, even when a physician or his assistants are bending over the patient. ■



TRENDS IN AIR CONDITIONING

by DONALD L. SNOW and RICHARD P. GAULIN

Noting that improvements in the quality of operating room air from a bacterial standpoint seem related to a reduction in wound sepsis rate, the authors examine recent developments in design and operation of air conditioning systems for surgical suites. Factors in operating room ventilation and the control of air movement in the surgical suite are also discussed.

THE WRITERS, as members of a group* examining air conditioning design principles for operating rooms, have been impressed both with the wealth of published information and current investigations which hold promise of completing needed areas of fundamental information in this field within a reasonably early period.

Nevertheless, the dilemma confronting the air conditioning engineer is how he may, until this basic information is secured, simultaneously design for: (1) control of electrostatic hazards, (2) efficient removal of flammable anesthetic vapors and odors, (3) physical comfort of the operating room occupants, and, (4) maximum air quality within the operating room from a bacteriological point of view.

Air conditioning can help reduce electrostatic hazards in operating rooms and other anesthesia induction locations by maintaining the relative humidity at not less than 50 per cent, as required by the NFPA Code 56[1]. To remove flammable gases, the same code states that the exhaust air outlet in these rooms should be located near the floor "and as near as practicable to the planned location of the anesthesia machine or head of the surgical table".

Less definite design criteria are available for the thermal comfort of the room occupants. There is evidence of a growing demand by some surgeons for lower ambient temperatures. The preference today is in the range of 70° to 75° F. rather than in the range of 68° F. to 80° F. for the operating room frequently mentioned in the literature. Temperatures of 65° F. and

*Members of the Committee on Hospital Facilities, American Public Health Association, currently investigating health-related principles in operating room air conditioning design and maintenance practices.

lower are sometimes being requested. This seems to be particularly true of those surgical specialties where the operations are of long duration and where staff members wear extra surgical outer garments. Thermal comfort also requires that air movements within the area occupied by the surgical team be held to a velocity of less than 50 feet per minute[2] (where skin surfaces are exposed). These criteria are primarily designed for the active members of the surgical team, the premise being that patients can be suitably draped for their thermal comfort.

AIR QUALITY IN O.R.

Of the problems confronting the engineer in air conditioning the surgical suite, the one of greatest concern is to maintain the quality of the air within the operating room. Bourdillon and Colebrook's experiences with ventilating and filtering air in burn dressing rooms helped substantially to focus attention toward this area. They proposed operating room air quality standards starting with 10 down to a lower range of 2 to 0.1 bacteria-carrying particles per cubic foot of air, depending on the type of tissues involved in the operation[3]. The findings of Shooter and his colleagues[4] have indicated a relationship between a reduction in the wound sepsis rate and improvements made in the bacterial quality of the operating room air.

The literature points to three major areas of concern where air conditioning, including ventilation, can significantly affect the amount of air-borne contamination in operating rooms. These comprise:

1. Design and operation of air conditioning systems.
2. Factors in operating room ventilation.
3. Control of air movement in the surgical suite.

AIR CONDITIONING SYSTEMS

The fresh air supply at the building air intake has been indicted only infrequently as a possible cause of surgical wound infection hazards, although Fredette[5] has demonstrated that anaerobic spore formers may be introduced from this source. A much more common source for air contamination yet to be evaluated as a factor in wound infection are the slimes found on the wet cooling coils of both 100 per cent supply air and partial air recirculation types of air conditioning systems. Chemical additives to spray systems are being used to control growth on coils, but care must be exercised in their selection in order to avoid those having toxic or corrosive properties. Air conditioning systems that include equipment using hygroscopic salt solutions and salt regenerating features in place of cooling coils are reported to avoid this problem.

Within the past few years there has become available a wide variety of air filters to provide almost any degree of air cleanliness desired. Various efficient and economical combinations of air filters and electrostatic precipitators are being used frequently to reduce dust and bacterial loadings in air conditioning systems.

One trend noted is to include final, or "polishing" filters either at central locations in the air conditioning systems or near the individual operating room supply air grilles. Air filter media, with low pressure loss characteristics and National Bureau of Standards Dust-Spot Test Method efficiencies in the 80 to 90 per cent range, are found useful for this purpose. Filters of any type present problems in routine maintenance, particularly with respect to their regular replacement. Manometers are now being used more often to indicate the necessity for cleaning or replacement of filters and to eliminate reliance on visual inspections.

Because air-borne pathogens are being constantly released through normal activities within the operating room, the use of filters having dust-spot test efficiencies of 99+ per cent in the air conditioning system contributes few additional benefits and does not appear justified under normal operating room situations.

The chief factor in reducing air-borne contamination by means of the ventilating system is the dilution effect due to the air change rate. And the crux of the air conditioning designer's problem is how any increase in the air change rate, over and above those based on computed thermal loads, can be justified.

As many as 20 air changes per hour—well over the 8 to 12 per hour normally required for average operating room thermal loads in the continental United States—have been suggested to improve the bacterial quality of the air[6]. Because these proposed higher ventilation rates are based on observations of conditions in specific operating rooms, they may not be generally applicable. Whether they are will depend on first investigating certain fundamental relationships. For example, Blowers suggests that slit and sedimentation air sampling procedures should be conducted near the site of the surgical incision and during the period that the wound is open. These data, he feels, should then be compared with wound sepsis rates[7]. Until these are determined, a sound basis for optimum ventilation rates cannot, with any certainty, be settled. Nevertheless, with evidence now available, it would seem prudent to design for ventilation rates that exceed those required for maximum expected thermal loads.

COSTS BELIEVED EXCESSIVE

Some hospital authorities believe that costs of heating and cooling outdoor ventilation air at any of the rates mentioned above are excessive. This fact has stimulated a search for methods that will provide equal protection at less cost.

The obvious and most frequently proposed substitute for ventilation is the reuse of the surgery air by recirculating it. Because of the known contamination of air within the surgery, most hospital authorities prefer the use of outdoor air —which is conceded to be relatively free of pathogenic organisms—and they are reluctant to rely upon the more complicated systems necessary to sterilize the contaminated air for reuse. To duplicate the quality of outdoor air, these systems require specialized equipment, such as a combination of particulate and odor removal filters with additional fan power for air delivery. Further, a meticulous maintenance program is needed to insure efficient operation.

To reduce a large part of the operating cost of using outdoor air systems, there is a trend to design the systems to use outdoor

air during the six to eight hours the surgery is in use. During the off-hours, the quantity of outdoor air is reduced by recirculation.

FACTORS IN O.R. VENTILATION

The concept of the operating room "ventilation rate" is being studied by various investigators who are determining ventilation rates in that part of the room where the patient is—the top of the operating table. Studies in progress by such investigators as Williams and Lidwell, and other studies now being initiated in this country, are attempting to determine bacterial dispersion patterns when air-borne contaminants are released at different points. This is to simulate the effect of surgical personnel stationed around the operating table under different room air inlet conditions. Much interest has been stirred by the "piston" method of room ventilation which has been shown to uniformly clear a room of uniform contamination[7]. This piston method introduces supply air over the total ceiling area and forces it to move uniformly toward the floor, where it is exhausted. The piston method is more effective during the heating cycle than the cooling cycle for the removal of air-borne contaminants. Shooter, et al[4] noted some evidence that the reduction in incidence of surgical wound sepsis may be due to the avoidance of zones of still air over the operating table. One type of air inlet arrangement, which directs a stream of air toward the operating table, has been reported to improve the bacterial quality of the air, but has not produced any significant reduction in the sepsis rate[8]. Such factors as the locations of local sources of contamination within the room, including surgical personnel and their movements, velocity and density of room air currents, and the effect of cold on air movement, may help explain these apparent anomalies. Hence, the available literature is not conclusive in demonstrating whether various supply air grille and other air diffusing systems enhance or mitigate local ventilation rates at the operating table.

These developments suggest that the criterion for providing personnel thermal comfort in operating rooms may need to be modified by ventilation requirements which promote the clearance of air-borne contaminants.

The optimum locations of exhaust registers in operating rooms are also undergoing intensive study by several groups. Preliminary observations of various exhaust arrangements with the "piston" ventilation method are reported to show substantial variations in the ventilation rate measured at the operating table.

CONTROL OF AIR MOVEMENT

Several workers have independently noted and confirmed the cross-infection hazards of contaminated air sucked from corridors and other areas into the operating room[4, 9]. Based on this, extensive efforts are now being made in the design of some surgical suites to develop air pressure gradients between the operating rooms and their ancillary areas in the surgical suite and the remainder of the hospital. Air lock arrangements are being developed to maintain intermediate air pressure zones in anesthesia induction rooms, scrub-up and sterilizing rooms, and to maintain normal atmospheric pressures in clean-up rooms and access corridors[10].

Another mechanism for air currents which has potential significance as a cross-infection risk has been reported by Bourdillon[11]. This is the displacement effect which air, in areas adjoining the operating rooms, can exert when held at a temperature different from the operating room. When communicating doors are opened, density currents are set in motion. Air may pass out the top of the door in one direction and in at the bottom or vice versa. Blowers relies on positive exhaust from the operating room and on weighted dampers in the walls for the free escape of air. When the doors leading to the operating room are opened, all dampers close and the entire air supply is available to pass out the door opening[7]. ■

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Donald L. Snow and Richard P. Gaulin, as chairman and member, respectively, of the Committee on Hospital Facilities of the American Public Health Association Engineering and Sanitation Section, have been closely examining air conditioning design principles and maintenance programs for operating rooms. Mr. Snow is chief of the sanitary engineering branch, Division of Research Services, National Institutes of Health, Bethesda, Md. He is a past director of the Institute of Sanitation Management and former secretary and editor of the Inter-American Association of Sanitary Engineering.

For the past 11 years Mr. Gaulin has served as supervisory mechanical engineer for the Division of Hospital and Medical Facilities, Bureau of Medical Services, Public Health Service, Washington, D.C. He represents the American Society of Heating, Ventilating and Air Conditioning Engineers on the National Fire Protection Association Committee for "Code for Use of Flammable Anesthetics".

THE UNITED States Naval Hospital at St. Albans, N.Y. has conductive vinyl flooring in its surgical suite. This type of floor covering is a comparatively recent development.

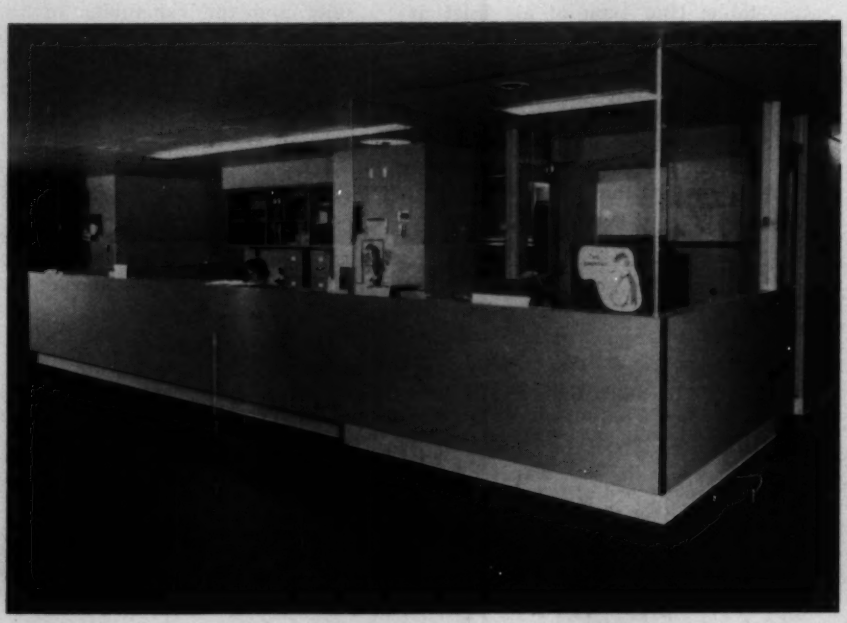
Cleanability
is a prime factor in

CHOOSING FLOOR, WALL AND CEILING COVERINGS

by WILLIAM R. O'CONNELL

Wall and floor finishes for the operating room must be easily cleaned, inexpensive to maintain, slip-resistant, fireproof, "flexible" and pleasant in color, the author states. He analyzes the most widely used materials now available on the market, explaining which finishes completely meet all requirements and which finishes need special installation techniques to attain operating room standards.

AFTER THE SURGEON finishes his tense and exacting work comes the dull part of the proceedings. It is time to clean up. Then the cleaning crew berates the architect and builder for putting in the plain



CERAMIC tile covers the floor outside the surgical control station and supervisor's office at University Hospital, the University of Washington, Seattle. To insure satisfactory cleaning in surgical suites, a hardener should be used in tile joints.

SIX YEARS ago, this conductive terrazzo floor was installed at the Clinical Center at the National Institutes of Health, Bethesda, Md. Regular use of recommended cleaners has kept these floors good looking and safe. Walls are covered with glazed tile.

plaster painted wall that does not withstand heavy day-to-day scrubbing. But one wonders if this painted plaster wall that needs frequent repainting is not better than the ceramic tile wall with mortar joints that are so difficult to clean. To some extent, structural glazed tile, structural glass, laminated plastic, prefinished hardboard and marble have this same joint trouble. When any of the materials which require mortar joints are used, a cement hardener should be added to the joint material.

TRENDS IN WALL FINISHES

Laminated plastic and vinyl-covered fabric wall coverings eliminate much of the objection to the high-maintenance plaster wall and the hard-to-clean joints of the tile wall. There is a trend to use more vinyl and plastic wall coverings, since they present a minimum of joints and help the over-all acoustics of the room. Although it is expensive, one wonders why stainless steel, which has proved so satisfactory for operating room cabinets, has not been used more on operating room walls.

The basic considerations in the selection of an operating room wall finish are:

1. It should have a smooth finish.
2. It should be impervious to moisture.
3. It should not have too high a light reflectance value.
4. It should withstand heavy abuse from movable equipment.
5. It should withstand repeated cleanings with a minimum of maintenance.
6. Color should be restful and pleasing to the eye.
7. It should make a smooth transition to the base and floor.

ACOUSTICS AND CEILINGS

Ceilings of operating rooms are usually of painted plaster. This should be a smooth plaster finish painted with a dull gloss paint. There has been a trend to give more acoustical treatment to operating room areas. Of course, such treatment has been primarily used for the ceiling, since it is the area with the least amount of wear. Loose fiber acoustical tile and acoustical plaster should be avoided because of the tendency of small particles to fall off. In this day of staphylococcal infections, regular acoustical tile with holes at intervals and metal pan acoustical tile have real disadvantages—they provide a dark inaccessible space for bacteria to hibernate.

Today, the best available material on the market for acoustical treatment of operating rooms is acoustical tile covered with a thin vinyl membrane. This tile gives better washing qualities than painted plaster and also provides acoustical treatment.

FLOOR COVERING TYPES

Economy should never be allowed to dictate the type of floor covering used. For sanitation and

maintenance, the floor should not be porous nor subject to cracks and openings. It should not be slippery nor hazardous to movement. The floor must be easy to maintain, but at the same time capable of withstanding heavy traffic and repeated cleanings. As in the rest of a contemporary hospital, the operating room floor should be fireproof. Usually a three- or four-hour fireproof rating is desirable.

Broadly speaking, the selection of an operating room floor depends on safety, sanitation, durability, texture, color, flexibility and maintenance economy. The floor color should be pleasant enough to diminish the patient's fears and at the same time reduce glare and reflections. The floor colors must, of course, blend with the over-all color scheme of the room. The floor should be flexible; that is, it should be adaptable to corners, columns or offsets. It is wise to have a cove base made of the same material as the floors.

Electrostatic potentials in operating rooms must be controlled, and any floor material used should comply with resistance ratings of the National Fire Protection Association Code No. 56.* If the floors in an operating room are as much as 10 years old, chances are 100 to 1 that they do not meet the requirements of this NFPA code.

MEETING THE NFPA CODE

Many materials available on the market today completely meet the requirements of the NFPA code and most of the requirements that have been previously mentioned. Oxychloride cement, conductive linoleum and conductive terrazzo were three of the first such products on the market (terrazzo with the 4 in. or 6 in. square metal grid is not an acceptable floor). There has been trouble with oxychloride cement and terrazzo floors because the material is mixed on the job and is not subject to the close laboratory controls of linoleum, vinyl or ceramic tile. Where terrazzo floors have failed, it is usually because the carbon black used in the bonding cement weakens the mortar. If the binder is not properly mixed, the mortar will tend to disintegrate. Terrazzo and oxychloride cement floors, when properly applied, are two of the best operating room floor finishes; they give a continuous surface of floor and base with a minimum of cracks.

*NFPA Code No. 56 is entitled, "Code for Use of Flammable Anesthetics".

PROBLEMS AND SOLUTIONS

Conductive linoleum, which was widely used for a time, has proved to be an excellent floor. The main objection to this floor was its black color. Conductive vinyl floors are now available. These floors are available in more pleasing colors than black, but have the disadvantage of more joints. For a time, a lack of dimensional stability in vinyl floors caused trouble. The manufacturers have now overcome this problem. Vinyl floors are considered the best of the soft conductive operating room floors.

Ceramic tile is now available in a conductive tile for operating rooms. When a hardener is used in the joints, ceramic tile makes an excellent floor. The joints in the floors are the biggest problem from the maintenance standpoint. Some problems have arisen from individual tiles working loose; this happens because the tile must be set in a conductive cement bed containing carbon black, and the carbon black weakens the bond of the cement.

For use on existing floors which are not conductive, satisfactory paint or spread-on materials are available. Vinyl tile, because it is a relatively thin material, can be installed successfully over existing floors.

Windows, glass block and skylights in operating rooms have become obsolete. It is easier to maintain the proper lighting and room temperature when nature is not relied upon. Consequently, the problem of natural lighting and ventilating need not be discussed. However, lighting fixtures, air-conditioning grilles, switches and clocks must be contended with. These should be recessed flush with the wall or ceiling in which they are placed.

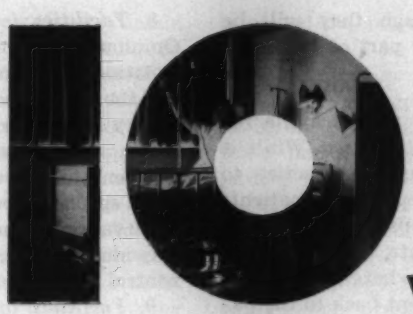
CABINET REQUIREMENTS

Quite often one entire wall, or the major part of it, is devoted to instrument and storage cabinets. These cabinets are usually of stainless steel or metal with a baked enamel finish. Cabinets should be free of dust catchers. Doors opening into the room are usually of painted wood. Many of the newer hospitals are using laminated plastic covered doors in operating suites, and eliminating the common metal kickplate.

The ideal operating room would be the inside of a colored, seamless, conductive, stainless steel ball with a flat portion (floor) coved to the side walls. This flat portion would act as the working surface. The inside could then be cleaned with a steam germicidal spray at the start and conclusion of each operation. If available as a prefabricated operating room with all mechanical equipment built in, this room would be the answer to the problems discussed in this article. ■

the author

William R. O'Connell, architect and hospital consultant in Austin, Tex., draws on his more than 10 years of experience in working with hospitals as an architect and consultant to present this guide for selection of wall, floor and ceiling coverings for hospital operating rooms. Mr. O'Connell has been associated with the architectural firm of O'Connell and Probst, Austin, Texas, since 1950. Prior to that time, he served as consulting architect for the Hospital Survey and Construction Division of the Texas State Department of Health. He has also engaged in architectural work in Daytona Beach, Fla., and in Atlanta, Ga. A registered architect in Texas, Mr. O'Connell is a member of American Institute of Architects.



10 VARIABLES THAT GOVERN RECOVERY UNIT REQUIREMENTS

by ALBERT H. SCHEIDT

Size, format and location are the principal determinants in developing the "perfect" postanesthesia recovery room design, the author states. In this article, he explains how individual hospitals can evaluate these factors in deciding their recovery room needs.

IN AN EFFORT to reduce surgical mortality and morbidity, many hospitals have resorted to the development of a postanesthesia recovery room, both staffed and equipped to better meet this need. The current estimate of hospitals having a facility of this sort is approximately 45 per cent; this figure is constantly increasing.

RECOVERY ROOM: AN OLD CONCEPT

Contrary to popular opinion, the postanesthesia recovery room, as well as the intensive care unit, is not a recent concept. While its design, size and location may have changed, the concept that the immediate postoperative patient requires special attention and special equipment is as old as surgery itself. Literature first mentions this concept in an 1863 publication by Florence Nightingale entitled, *Notes on Hospitals*. Therein is stated the following: "It is not uncommon, in small country hospitals, to have a recess or small room leading from the operating theatre, in which the patients remain until they have recovered, or at least recovered from the immediate effects of the operation."

Throughout the years many different approaches have been used in attempting to attain the objectives of a postanesthesia recovery room. Florence Nightingale moved in this direction by concentrating the most serious cases nearest the nursing station in an open ward. A similar pattern was developed in the early days in this country when open ward nursing was the principal type of patient facility. As emphasis began to be placed on privacy and as the hospital became more and more a place to get treatment rather than a place to die, the special duty nurse became the medium for focusing special attention.

With the decline in number of special duty nurses as related to the demand for this service, group nursing was developed as an alternate means for giving the patient this special attention. This usually consisted of using a regular patient division on the same floor as the surgery suite with a substantial increase in the number of nurses on that division. Many of us had a first introduction to a "so-called" recovery room during World War II in army general hospitals.

A few recovery units did exist in civilian hospitals prior to World War II, but the real impetus came as a result of the experiences of many physicians and a limited number of administrators with recovery rooms in the military service. Several medical factors also contributed to this interest.

Anesthesiology had made great strides in shifting from nurse anesthetists to physician anesthetists. Similarly, the scope of surgical procedures had increased and had been extended to include poorer operative risk cases, particularly because of the advances in anesthesiology. Equipment to enhance the patient's opportunity of recovery had also been developed and needed to be concentrated in one location to be readily available.

THE 'PERFECT' LAYOUT

To attempt to demonstrate one layout as a "perfect" recovery room would disregard all of the variables which must be taken into consideration before developing a working drawing. Most hospitals have approached the problem of developing a recovery room through the committee method. Most committees consist of the chief of surgery, the chief of anesthesiology, the surgical supervisor, the engineer and/or architect and the administrator. Again, in most cases, this committee has had to consider factors pertaining to: a) size; b) format; c) location, and d) special considerations.

The factors which the committee should evaluate in determining size include the following:

1. Number of operations per day, major and minor.
2. Types of operations per day, major and minor.
3. The spread of operations during the day.
4. The extent to which the recovery suite will be used.
5. Climatic conditions.

6. Patient bed equipment.
7. Other equipment needed in the recovery suite.
8. Facilities for isolation cases.
9. Facilities for terminal cases.
10. Methods of handling visitors.

SIZE DETERMINANTS

1. *Number of operations per day, major and minor.* This is merely a starting point on which the committee may come to close agreement rather rapidly, with the hope that it will cultivate a willingness to agree on more controversial items. Where the hospital is already in existence, factors affecting the answer to this and several of the following items may be drawn from past experience, plus projected future needs. Where the hospital involves an entirely new operation, experience in other hospitals in the community may assist in determining these questions. Where no other hospitals exist, probably the best approach is to secure data from hospitals in neighboring communities of about the same size with medical staffs comparable to the proposed medical staff of the new hospital.

2. *Types of operations per day, major and minor.* The term "major and minor operations" has different meanings in terms of the amount of time the patient will spend in the recovery room. When the hospital is heavy on heart surgery, chest surgery and neurosurgery, the number of beds required in the postanesthesia recovery room will have to be much greater than if the hospital limits itself to more simple procedures requiring less recovery room time.

3. *The spread of operations during the day.* The number of available operating rooms and the administrative attitude toward concentrating cases during the early morning hours will likewise have a tremendous effect on the number of beds needed. If, because of lack of operating rooms or of administrative attitude, operative cases are scheduled throughout the day, one recovery room bed may suffice for two or three cases. On the other hand, if the attitude is one of heavy booking in the early morning hours with very few cases handled during the late morning or early afternoon, many more beds will be needed to meet the need, even though they will be empty a greater part of the day.

EXTENT OF USE

4. *The extent to which the recovery suite will be used.* While it is becoming common practice to route all postoperative patients through the postanesthesia recovery room suite, there are still some hospitals where minor surgery cases are sent back to the patient division. This is particularly true when no special equipment is needed and the case has a private duty nurse.

5. *Climatic conditions.* We are becoming more conscious of the effect of climatic conditions on the immediate postoperative patient. The question of whether or not to air-condition the division room to which the patient will be returned is a factor which must not be overlooked; it affects certain geographical areas throughout the year and other geographical areas in certain seasons.

6. *Patient bed equipment.* While this equipment is a relatively minor factor, it does affect the bed space needed and, in many instances, determines the size of door openings. It must be decided whether the patient is to be placed on a special recovery room bed in the recovery room or is to be transferred by cart to the recovery room and then transferred to a recovery room bed or, as an added alternate, transferred to his own bed from the operating table and then rolled to the recovery room.

EQUIPMENT AND STORAGE

7. *Other equipment needed in the recovery suite.* This factor involves both the equipment needed for the bedside care of the patient and a place for its storage when not in use. The relationship of the recovery room to the central sterile supply department is the primary governing factor in evaluating how many trays of each variety must be kept in the recovery room storage area. Similarly, the question of whether oxygen and suction are to be piped in, or are to be administered by individual units, has an effect on space needs. In fact, before resolving the question of space needed for equipment, the committee needs to explore a number of similar considerations.

8. *Facilities for isolation cases.* Opinion is divided as to whether isolation needs can best be achieved on the open postanesthesia recovery ward through good technique, or whether a special room adjacent to the ward is required. If a special room is used, glass observation windows should be provided in order to permit visual control of the patient's recovery.

9. *Facilities for terminal cases.* In the opinion of some administrators, including the author, some provision should be made so that a case which appears to be terminal can be removed from the open recovery ward and access to the patient can be permitted for the immediate family, as well as the pastor, priest or rabbi.

This not only discharges a moral and humane obligation to the family, but also eliminates the demoralizing effect of death for the other patients in the recovery ward. These patients are at a point in their recovery process when they are deeply concerned with their own chances of survival.

HANDLING OF VISITORS

10. *Methods of handling visitors.* To permit members of the immediate family into the recovery ward invades the privacy of the other patients, interrupts intensive care and may very easily cause breakdowns in technique. On the other hand, to expect visitors to "sweat out" the time the patient is in surgery *plus* the time spent in the recovery unit is a tremendous mental strain on the family. This usually becomes self-evident whenever someone from the "hospital family" is in the recovery suite; in these cases an exception is invariably made to the "no visitors" rule.

Two approaches to solving this problem have been made. The first approach is to place the patient temporarily in a room similar to the terminal room, allow the family a five-minute visit and then remove the patient to the open recovery ward. The second approach, which requires less nursing time, is to have a visitors corridor at a right angle to the main corridor leading to the operating room area. The common wall between the visitors corridor and the recovery ward should have glass portholes

over each bed with a curtain which is controlled from the inside.

Visitors, when called, would be permitted to view the relative through the proper porthole after the patient has been screened in by a cubicle curtain. The surgeon may likewise discuss the success of the operation briefly with the family while they are in the corridor. As he escorts them out, he should suggest the time they may return to visit the patient in the patient's own room. Following this the recovery division should be notified, the curtain drawn over the porthole, and the cubicle curtain drawn back in order to provide visual observation by the recovery room nurses.

Once these 10 factors have been agreed upon, the architect will be equipped to determine over-all space needs for the recovery unit.

The format or length and width of the recovery suite should meet several requirements. First, it should provide for visibility of all patients from the nursing station. Second, there should be easy access to all utilities from the nursing station. Third, complete maneuverability of any patient should be provided without the need to move other patients.

The location of the recovery room should likewise be considered by the committee with special emphasis on the following items:

1. It should be near the operating rooms, but not immediately adjacent to one of them.

2. If at all possible, it should be near the operating room suite workroom, or near the unit responsible for its sterile supplies.

3. It should be adjacent to the anesthesiology offices and preferably connected by a door in the common wall between the recovery unit and the anesthesiology offices.

4. It should be reasonably close to the doctors dressing rooms.

Where the operating room suite is in one wing of the building, a good line-up of services (in this order) would include the recovery suite, the anesthesiology offices, the operating room head nurse's office and supervisor's office on one side of the corridor leading to the operating rooms proper. On the other side of the corridor (in this order) would be the physicians locker rooms and surgical workrooms.

SPECIAL CONSIDERATIONS

In planning the postanesthesia recovery room, these special factors should be considered:

1. *Equipment.* Certainly equipment must be taken into consideration in determining the size of the recovery suite. The scope of this article, however, does not include suggestions on the degree of simplicity or of unnecessary complexity of the equipment required for such a unit.

2. *Other Uses.* With the redevelopment of intensive care units in the last several years, considerable question has been raised as to whether the postanesthesia recovery room could be enlarged and the two functions combined. In the author's opinion, this combination is doubtful.

First of all, a patient located in an intensive care unit is considered to be occupying a hospital bed. Therefore, movement from that unit after several days would result in his occupying another hospital bed in a new location. A person in a postanesthesia recovery room bed would ordinarily not be considered as occupying a hospital bed but would have his bed reserved for him in the patient area, whether it be in the intensive care unit or on a general division. To hold open the number of beds which would be required to cover both recovery and intensive care functions would result in a tremendous duplication.

The second reason for not combining functions is the distress and mental anguish suffered by the patient's family during the time that the patient is in the recovery unit. If the two functions were combined, neither would operate as effectively as they do when the family aspect is minimized in the immediate postoperative time but is recognized during the intensive care time.

3. The greatest problem in postanesthesia recovery suite layouts results from the concept that the patient is going to be placed with his head next to the wall and with the foot end of the bed extending into the room. Once in operation, a vast majority of hospitals have found that the anesthetist and the nurses quickly change this so that the head end of the bed projects into the room. This involves long stretches of tubing for suction and oxygen if these outlets are wall mounted. This problem, when coupled with such apparatus as intravenous stands and blood bottle holders fastened to the bed, provides a maze through which personnel must travel with the utmost caution.

In several recently built recovery units a step toward simplifying this problem has been accomplished by suspending these units from the ceiling. This gives more space for maneuverability of personnel, and helps avoid breakage and the accidental stoppage of function which can arise from the tubing being shut off by body pressure. ■

the author

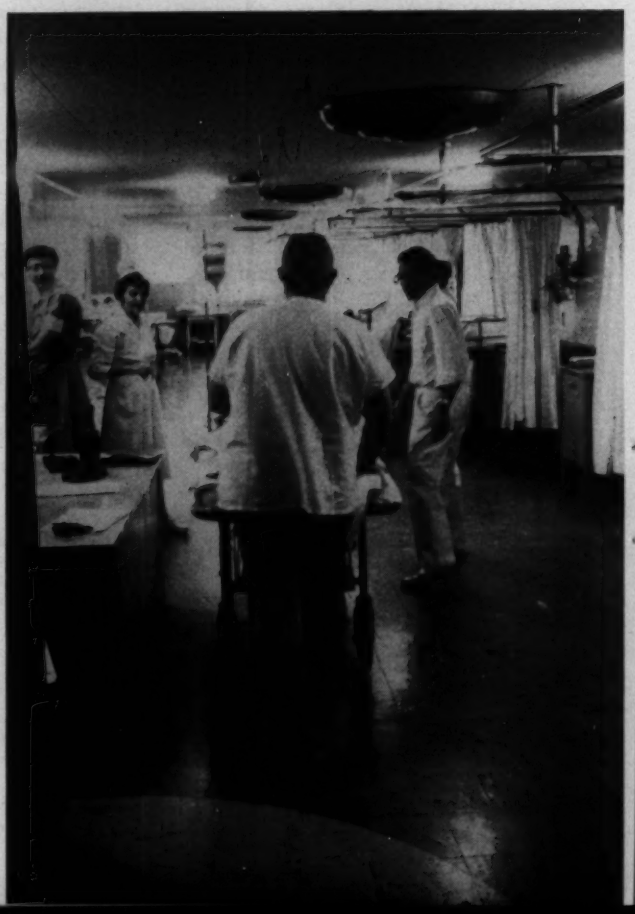
Albert H. Scheidt's 25 years of service in the hospital field have been marked by a continuous association with hospital construction programs. He was involved with the programing of a clinic building at Indiana University Medical Center, Indianapolis, and with a $2 million rehabilitation program for Chicago's Michael Reese Hospital before and after World War II. For 11 years he has been administrator of the Dallas (Tex.) County Hospital District. During that time Mr. Scheidt directed the construction of the $10 million Parkland Memorial Hospital. A fellow of the American College of Hospital Administrators, Mr. Scheidt is chairman of the Committee on Hospital Design and Construction of the American Hospital Association Council on Planning, Financing and Prepayment.

THE RECOVERY ROOM... where

Not too many years ago the postoperative recovery room was a brand new refinement in the hospital physical plant—a special room set aside for needed careful attention for all patients of general surgery in the sensitive interval following general surgery. Many hospitals had areas on the wards for giving special attention to these patients, but the advantages of a specially equipped room with its own staff adjacent to the operating rooms were obvious both from the standpoints of patient safety and efficient use of nursing resources.

Today, in most new hospitals a recovery unit is an essential part of the surgical suite. Modernization programs in older hospitals place the recovery room high on the list of needed facilities.

St. Luke's Hospital, Denver, established in 1881, added a post-anesthesia recovery room in a renovation program completed in July 1953. The room, with a capacity of 11 beds, is situated adjacent to the operating rooms and



BLOOD TRANSFUSIONS or intravenous fluids are started in the recovery room if necessary and ordered by the physician.

(CONTINUED)

doctors' lounge in space that formerly was a forgotten attic. It is a rather narrow room, with beds arranged on one side and work space on the other. But Mrs. Lillian Madden, a head nurse in the recovery room for nearly five years, considers this an advantage rather than a disadvantage. "And," she says, "the location couldn't be better."

During the normal 12-hour day, 25 to 30 patients are admitted to the recovery room and are discharged to their own rooms. When patients must be retained longer, special staffing is arranged to care for them.

Normal staffing includes two registered nurses, two licensed practical nurses, a nurse aide, a volunteer and an orderly. A registered nurse is on duty and in charge at all times.

Equipment in the room includes piped-in oxygen and suction, emergency equipment, such as cardiac arrest trays and tracheotomy trays, and all types of emergency drugs. During the time the patient is in the recovery room, blood pressure, pulse and respiration are taken frequently. Dressings are checked for bleeding, and the patient's color and general condition are closely watched.

"When there is an emergency," says Mrs. Madden, "it must be remembered that other patients cannot be ignored while everyone rushes to the emergency case—and this is the tendency. The staff must be divided so that all patients are being watched at all times."

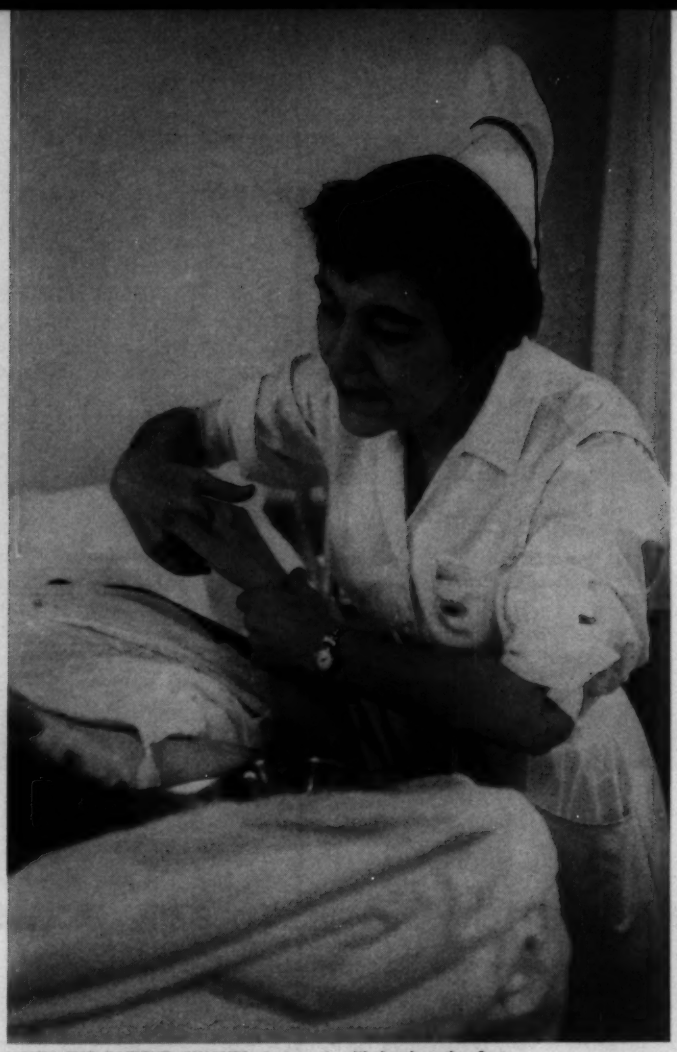
The recovery room staff is under constant tension with the knowledge that an emergency may be only moments away. It is not unusual that one of these emergencies is recorded in the pictures on these pages, which depict some of the activities of a typical morning in the recovery room at St. Luke's Hospital.

'tender loving care' achieves its fullest meaning

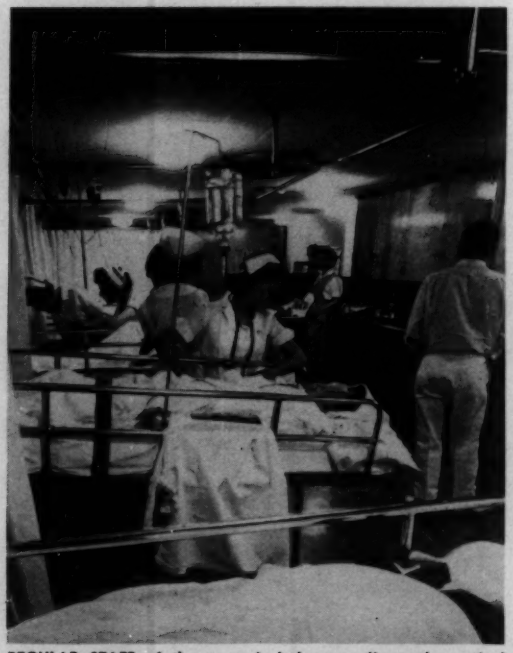
ARRIVAL OF ONE OF THE FIRST PATIENTS of the day is greeted by the recovery room staff as the patient is wheeled from one of the adjacent surgery rooms.

THE ANESTHESIOLOGIST follows his patient into the recovery room, and after listening closely to breathing sounds one last time, assigns the patient to the watchful care of the recovery room staff.

RECOVERY CART is set in place, suction and oxygen connections given another check, and an intravenous stand clamped into position. Cart can be completely curtained off if necessary.



WHEN THE PATIENT AWAKES, it is quite likely that the first face he sees will be that of Mrs. Lillian Madden, recovery room head nurse. "Patients are confused and uncomfortable when they awake, and require all the reassurance and comfort we can give them," Mrs. Madden says.



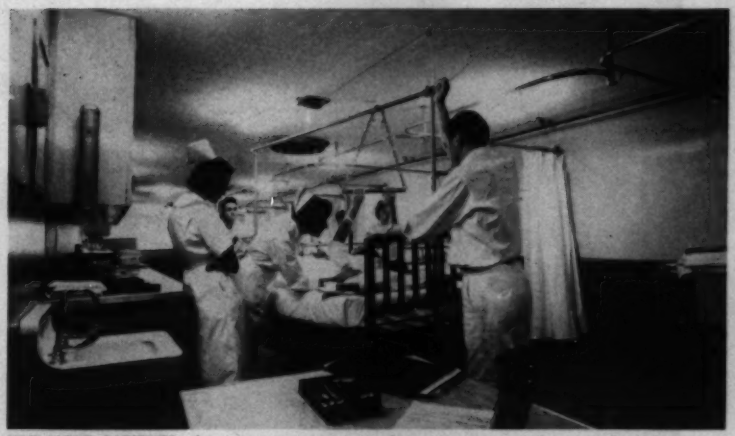
REGULAR STAFF of the room includes two licensed practical nurses. A student nurse (background) and an orderly also stand by to lend instant assistance.

THE EMERGENCY BELL is sounded when it is found that a young tonsillectomy patient is hemorrhaging severely. The bell is not switched off until a physician has reached the patient's bedside.

(CONTINUED)

A PHYSICIAN and an intern are on the scene within seconds, and two recovery room staff members are close by through the anxious moments until the bleeding is controlled.

THE CRISIS PASSED, the nurses smile their relief and turn to more routine tasks. Skill of the recovery room nurse is constantly tested, and the nature of her duties demands that she be alert, quick and efficient at all times.



FOR MOST PATIENTS, the recovery room is a short stopover on the way back from surgery. Here a patient in traction receives a final word of assurance from Mrs. Madden before being wheeled to a nearby elevator and to her room.

IN SPITE OF THE URGENCY and drama that frequently prevails in the recovery room, there is a good deal of routine work that must be done. Because of the rather large number of patients in and out of the room each day, there are numerous charts, forms, orders and records that must be processed promptly and carefully.

(ABOVE) A VOLUNTEER, also a regular staff member of the room, is helpful in many ways. Here she helps a homebound physician locate a chart that needs completion.

(RIGHT) NURSING TECHNIQUES are closely prescribed and rigidly enforced. Here the attention of the staff is called to a flaw in positioning intravenous medication equipment.

(LEFT) THE GREATEST SATISFACTION in being a recovery room nurse, the nurses say, is in helping patients through the difficult and often painful interval following a surgical procedure. Nurses give extra attention whenever they have the opportunity, and are ever watchful for sudden changes in the patient's condition. (RIGHT) THE SPIRIT OF DEVOTED ATTENTION to the wants and needs of the patient is strong in the recovery room, entwining itself in the actions of all those who serve there.

THREE CLOSE-UPS

of hospital surgical facilities

LUTHERAN GENERAL HOSPITAL .....page 74
Park Ridge, Ill.

Executive Director—V. W. Nelson
Architects—Burnham and Hammond, Inc., Chicago
Consulting Engineers—E. R. Gritschke and Associates, Inc., Chicago

UNIVERSITY HOSPITAL .....page 82
University of Washington, Seattle

Administrator—L. S. Rambeck
Architects—Naramore, Bain, Brady and Johanson, Seattle
Consultant—Carl W. Walter, M.D., Boston

GENERAL HOSPITAL OF EVERETT .....page 91
Everett, Wash.

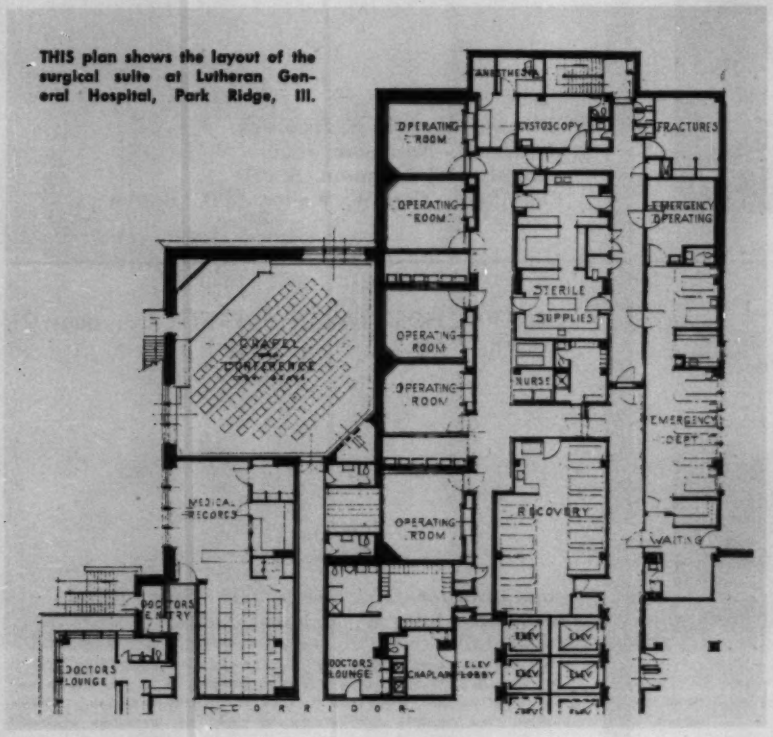
Administrator—Mrs. Cecile Tracy Spry, R.N.
Architect—John W. Maloney, Seattle

EACH of the five curtained cubicles in this emergency room is supplied with such equipment as resuscitation, oxygen and suction. A nurses' workroom is adjacent to the emergency room.

DUAL CORRIDOR SYSTEM ISOLATES SURGERIES

by V. W. NELSON

A DUAL CORRIDOR is the basic design system of the new Lutheran General Hospital in Park Ridge, Illinois. This type of planning allows all patient rooms to be on the outer perimeter of the building with work areas and nurse stations in the center core. This same plan exists in the surgical suite which has two corridors with the work areas and recovery room in the center. One side of the surgical suite contains five major operating rooms; we consider this the clean side. The other side of the work area contains emergency rooms and cystoscopy, endoscopy and fracture rooms; these can be considered the unclean side of surgery. The plan allows outpatients and those not properly garbed to be kept from entering the clean side of surgery.



THIS plan shows the layout of the surgical suite at Lutheran General Hospital, Park Ridge, Ill.

LAYOUT AND EQUIPMENT

The ambulance entrance (located in the lower right-hand corner of the accompanying plan) provides an area for police, relatives to wait while the patient is brought into the emergency room. The emergency room has five curtained cubicles, each of which is equipped with the necessary equipment for emergency care, including resuscitation, oxygen and suction. Immediately adjacent to the emergency room is a nurses' workroom. This workroom also opens into an operating room where nonscheduled cases can be given more extensive care.

The fracture room is fully equipped with its own radiographic unit (ceiling-mounted) so that x-rays can be taken without moving the patient to x-ray or having a portable unit brought into the area. The cystoscopy room is also

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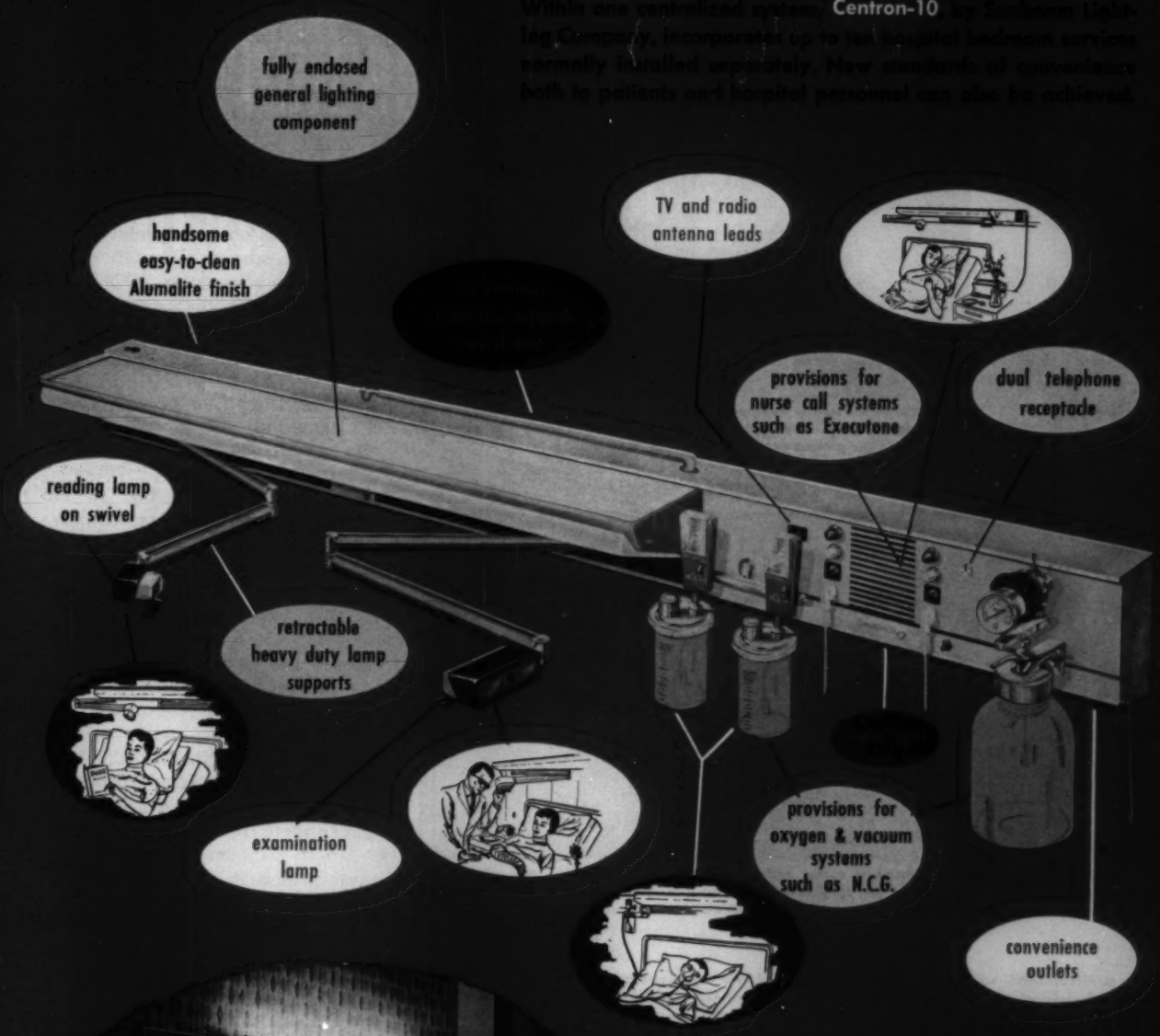
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retractable heavy duty lamp supports
examination lamp
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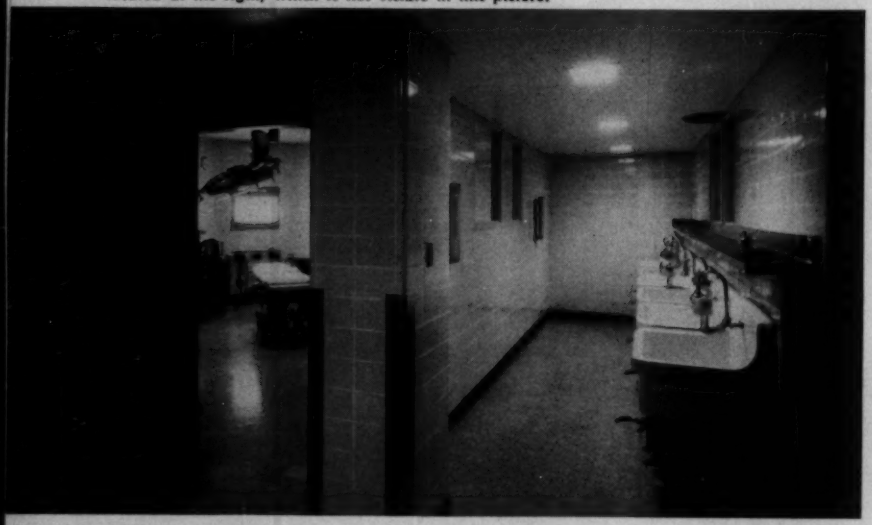
THIS cystoscopy room is equipped with its own individual ceiling-mounted radiographic unit. X-rays can therefore be taken without the need to move either the patient or a portable x-ray machine.

THE EMERGENCY room, orthopedic room, endoscopy and cystoscopy rooms are all included in this "unclean" corridor in the surgical suite. Located outside the rooms are the zoning valves for both nitrous oxide and oxygen, and the x-ray control units.

A PHYSICIANS' scrub area separates each set of two major operating rooms at Lutheran General Hospital, Park Ridge, Ill. Sharing this area are the room at left and an operating room located at the right, which is not visible in this picture.



equipped with a radiographic unit, so that this room is self-sufficient. A small darkroom immediately adjacent serves both the fracture and cystoscopy rooms.

Inpatients come down from the patient floors on service elevators; they enter surgery through electrically operated doors. This permits the doors to the clean area of surgery to be kept closed and eliminates bumping of the doors by carts.

In the major operating rooms is a panel built on an angle, which supplies nitrous oxide and oxygen and suction for both the surgeon and anesthesiologist. The major operating rooms are separated by physicians' scrub areas. These areas have windows so that the surgeons can look into the operating room to see when the preparations have been completed. After surgery the patient is moved into the recovery room for postanesthesia care. Upon completion of care in the recovery room, patients are wheeled out (through the door at the lower right-hand corner in the plan) to the service elevators and to their rooms.

Before surgeons enter surgery, they go through a lounge and then into their locker room where they change into scrub suits. From there they enter the surgical suite without ever going through the same corridors as the inpatients.

AIR INTAKE/EXHAUST SYSTEM

The surgical suite is completely air-conditioned; the system supplies 100 per cent outdoor air delivered at the required temperature and humidity during both winter and summer. The exhaust system expells all of the air to the outside of the building. No provisions have been made for the recirculation of this air; we believe that the use of outside air only will hold the concentrations of anesthetic gases in the suite to a permissible minimum.

The intake and exhaust fans are electrically interlocked so that both fans start and stop simultaneously from the switching point. This

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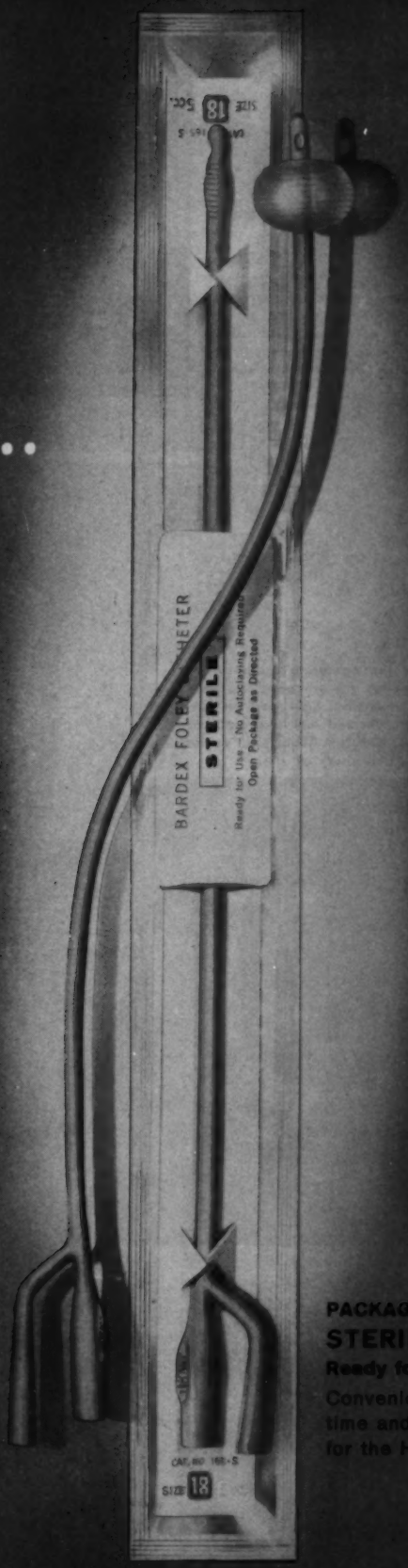

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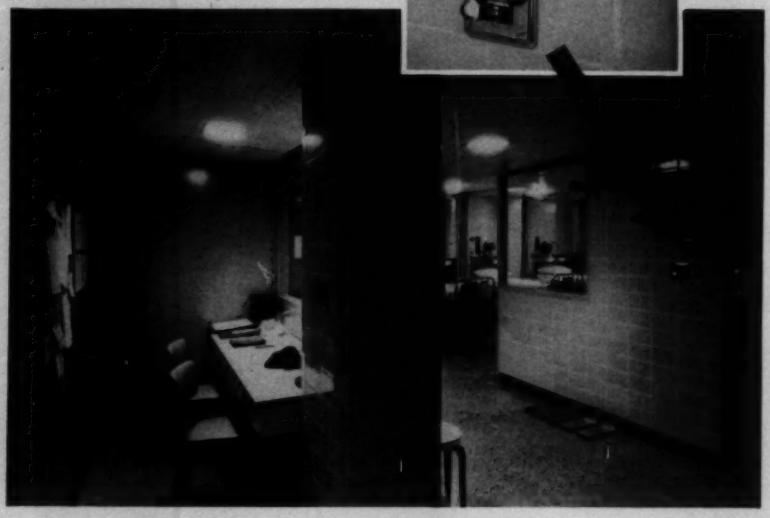
THESE two dictating telephones for physicians are situated at one end of the surgical corridor. For convenience, there is a similar dictating arrangement in the physicians' lounge at the other end of the corridor.

THE VIEW from the operating room supervisor's desk includes the nine-bed recovery room and the detecting light for an ungrounded circuit, located on the wall at right (see inset). On the floor is a device for testing the conductivity of shoes.



eliminates the possibility of running only the supply or the exhaust fan—use of only one fan would make the system inoperative.

The path of supply system from the fresh air intake damper is provided with a series of steam preheat coils, a set of throw-away type fibrous glass filters with a glass media backup, a set of electrostatic air filters, a sprayed-type chilled water cooling coil, a fan and a multizone reheat mixing box with hot water blast coils. The banks of the steam preheat coil, together with a steam-heated spray water heater, act together to provide air at the constant saturated temperature of approximately 55 degrees; this air is discharged by the fan into the reheat mixing box. The reheat mixing box has two compartments and the 55 degree air from the fan flows through the hot water reheat coil. The hot and cold air are then automatically mixed in the required proportion to maintain a room condition of 80 degrees dry bulb with 55 per cent relative humidity.

During the summer, when the cooling cycle is used, the steam

the author

V. W. Nelson considers participation in the planning of the new Lutheran General Hospital in Park Ridge, Ill., as the highlight of his career thus far. Located in a suburb northwest of Chicago, the hospital will be expanded to 450 beds as funds become available. A fellow of the American College of Hospital Administrators, Mr. Nelson has held offices in the Illinois Hospital Association. He currently serves as a member of the board of directors of Chicago Hospital Council. He holds a B.A. degree from Augustana College, Rock Island, Ill., and did postgraduate work at Northwestern University.

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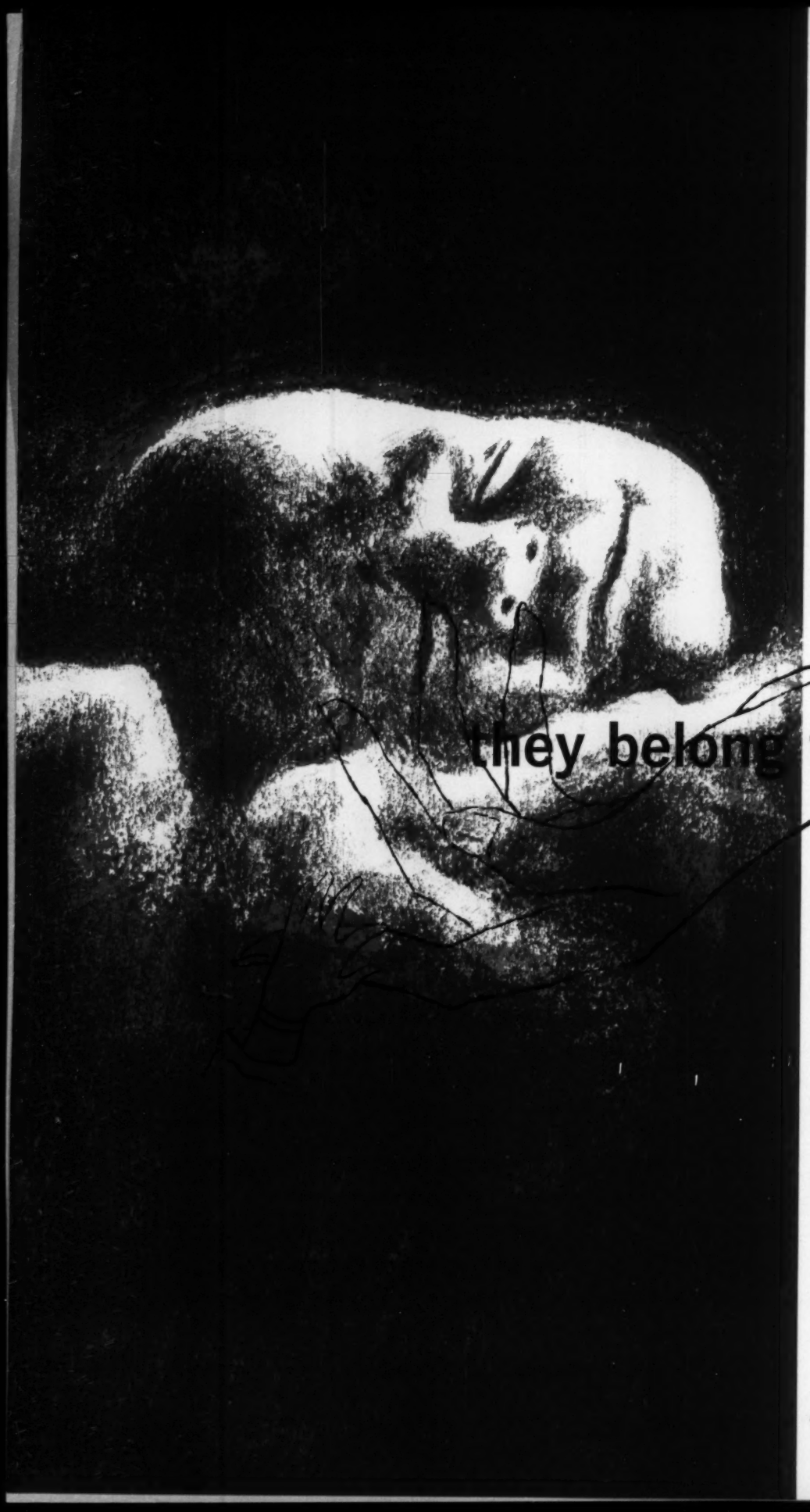

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preheat coils are turned off and the system handles 100 per cent outdoor air just as during the heating cycle. The chilled water cooling coil, together with the sprays to insure saturation, again maintains a fan discharge condition of approximately 55 degrees saturated. The blast reheat coil and the various mixing dampers for each of the rooms act the same as they do for the heating cycle.

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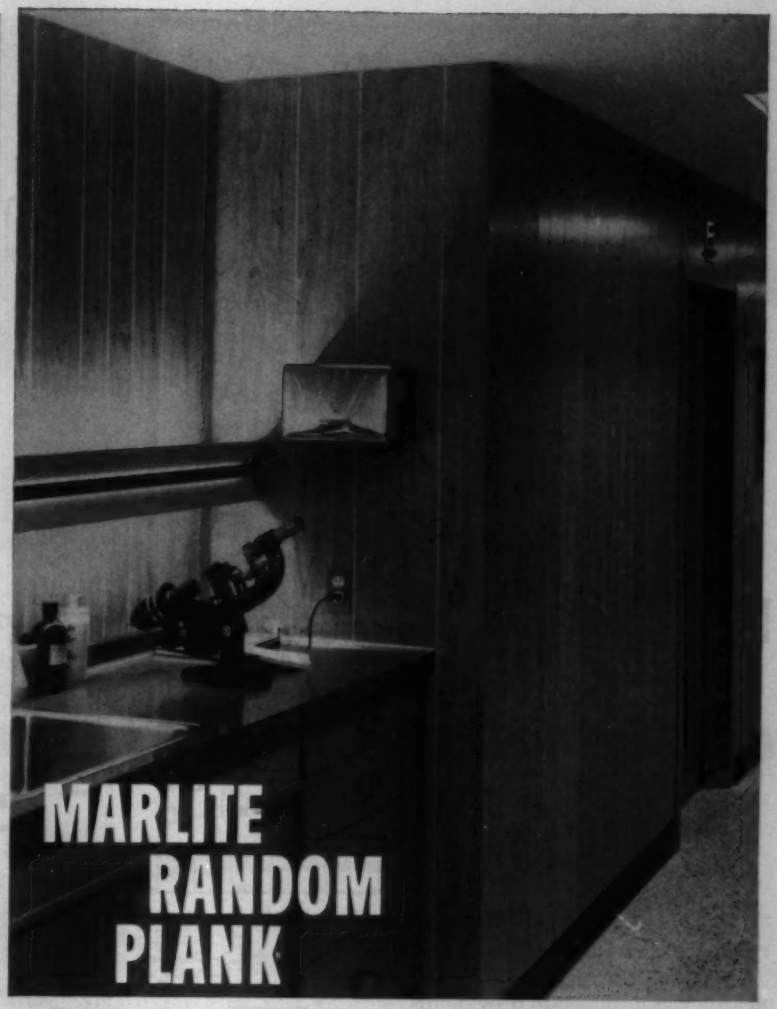
During the past few years, there has been considerable controversy among surgeons as to what are the most desirable operating room conditions. Accordingly, we have provided sufficient cooling coil capacity so that, in the operating rooms, we can maintain a summer condition between 72 degrees and 80 degrees and between 45 per cent and 55 per cent relative humidity. These conditions may be varied by adjusting the position of the controlled instruments for either winter or summer conditions.

In accordance with the National Board of Fire Underwriters Code requirements, an ungrounded electrical distribution system is provided for the operating and delivery rooms. The system is designed to reduce the hazards of electrical shock and arcs in the event of insulation failure. Circuit wiring is insulated from the conventionally grounded alternating current supply by the use of isolating transformers.

The entire surgery and emergency room area is covered with vinyl conductive floor.

A detecting and indicating device is provided to detect a ground fault in the system, and there are also alarm devices for the nitrous oxide and oxygen. Alarm devices are located within view of the operating room supervisor, switchboard and the chief engineer's office. Each room served in surgery from the electrical warning system is provided with separate branch circuits so that a temporary circuit failure, such as a blown fuse, will not affect other rooms. ■



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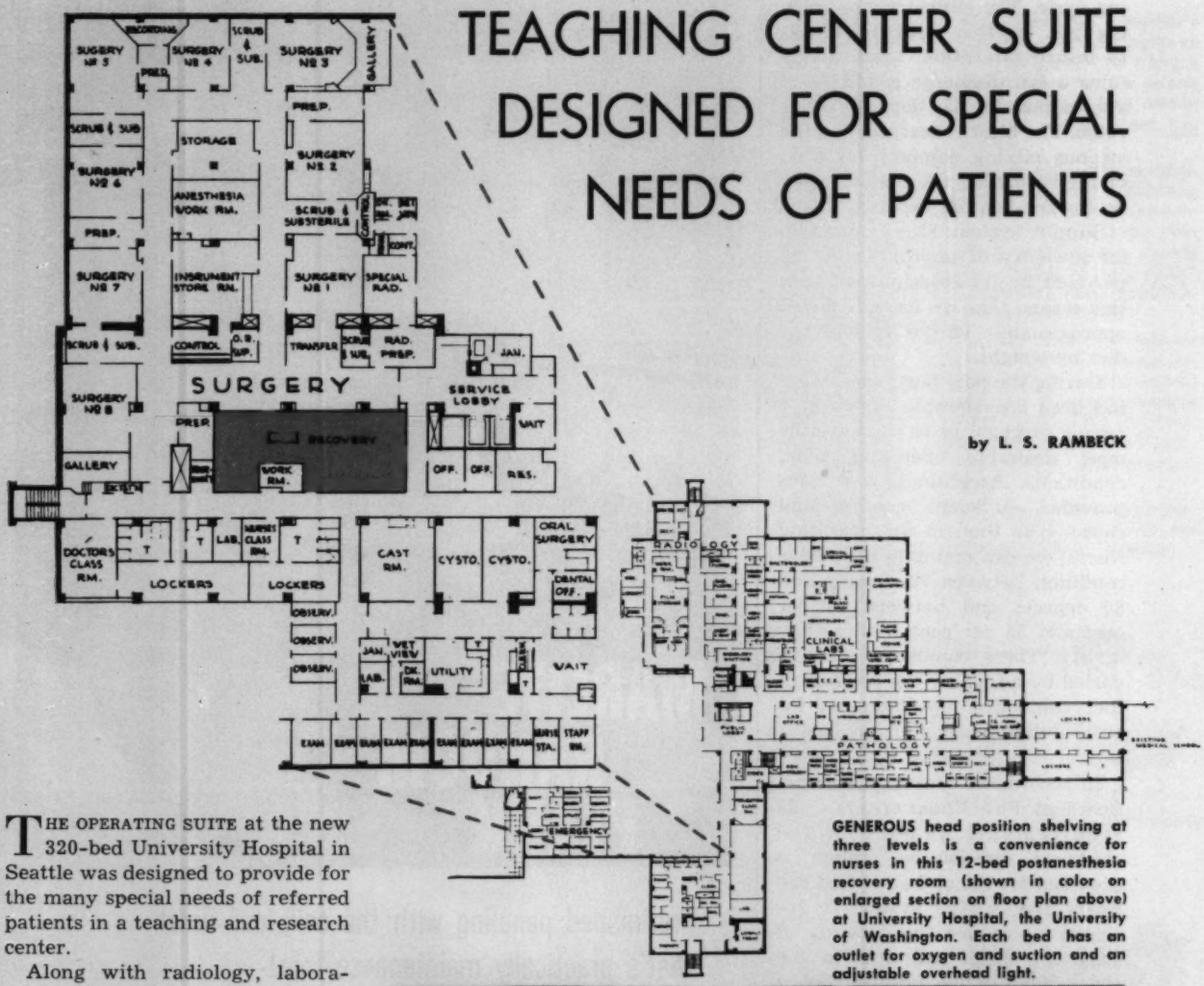

GENEROUS head position shelving at three levels is a convenience for nurses in this 12-bed postanesthesia recovery room (shown in color on enlarged section on floor plan above) at University Hospital, the University of Washington. Each bed has an outlet for oxygen and suction and an adjustable overhead light.

THE OPERATING SUITE at the new 320-bed University Hospital in Seattle was designed to provide for the many special needs of referred patients in a teaching and research center.

Along with radiology, laboratories, emergency service, and pathology, it occupies the second of the hospital's eight floors—away from heavy supply and human traffic. Such traffic is confined chiefly to the first and third floors which, because of the sloping land, are both at ground surface levels. The suite has the excellent operating advantage of adjacency to radiology and the emergency service, but is positioned so that it can function as an isolated sterile area.

GENERAL LAYOUT

The over-all facilities include a major suite comprising eight operating rooms, a 12-bed postanesthesia recovery room, offices for anesthesiologists, surgeons' lounge, lockers, waiting room for relatives, and a minor surgery suite which

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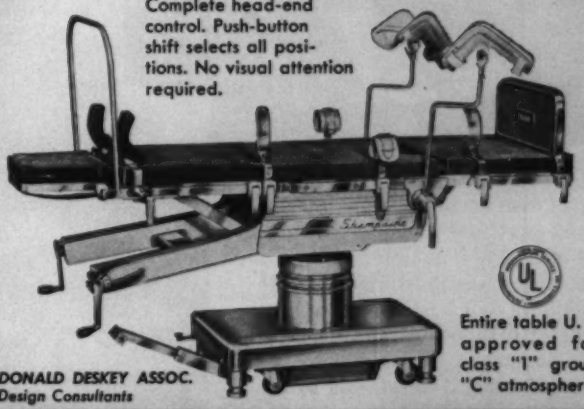

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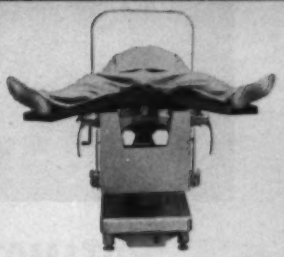

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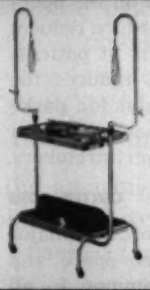

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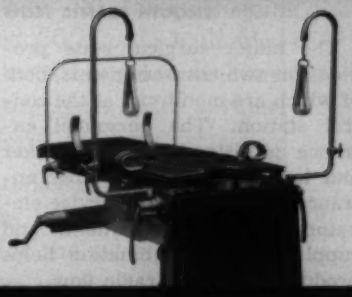

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RECORDING equipment gallery serves both the cardiovascular room and one other operating room. A swing suspension boom brings connections from the recording equipment overhead to the operating table. The surgeon and monitor are connected by a two-way communications system.

FEATURED in this scrub-sterilizing area are trough-type scrub sinks especially designed to eliminate splashing. The area has wall brush dispensers and, in the foreground, a high-speed autoclave and washer sterilizer.

has a cast room, two cystoscopy rooms, and two special rooms for oral surgery. The minor surgery suite was designed to provide examining rooms for the outpatient needs of orthopedics and urology. This has made it possible to restrict all general anesthesia to the second floor.

The major surgical suite has a double corridor "racetrack" general design with a transfer area, operating rooms, and recovery room on the perimeter, and with the control station, an instrument storage room, anesthesia workroom and an equipment storage room in the center core. Between every two surgery rooms is a preparation room with storage space for table parts and equipment at the rear. Also, between each set of two surgery rooms is a scrub-sterilizing alcove, with an instrument washer-sterilizer and a high-speed autoclave.

SMOOTH TRAFFIC FLOW

The major surgical suite provides for two entrance points, both of which are monitored at the control station. The personnel entrance is adjacent to the locker and lounge rooms. The other entrance, adjacent to the service elevators, is used for patients and supplies. This combination helps produce a smooth traffic flow.

Central dictating stations are placed near the surgeon's lounge outside the sterile area. These are connected to the hospital-wide central recording room in the medical records department.

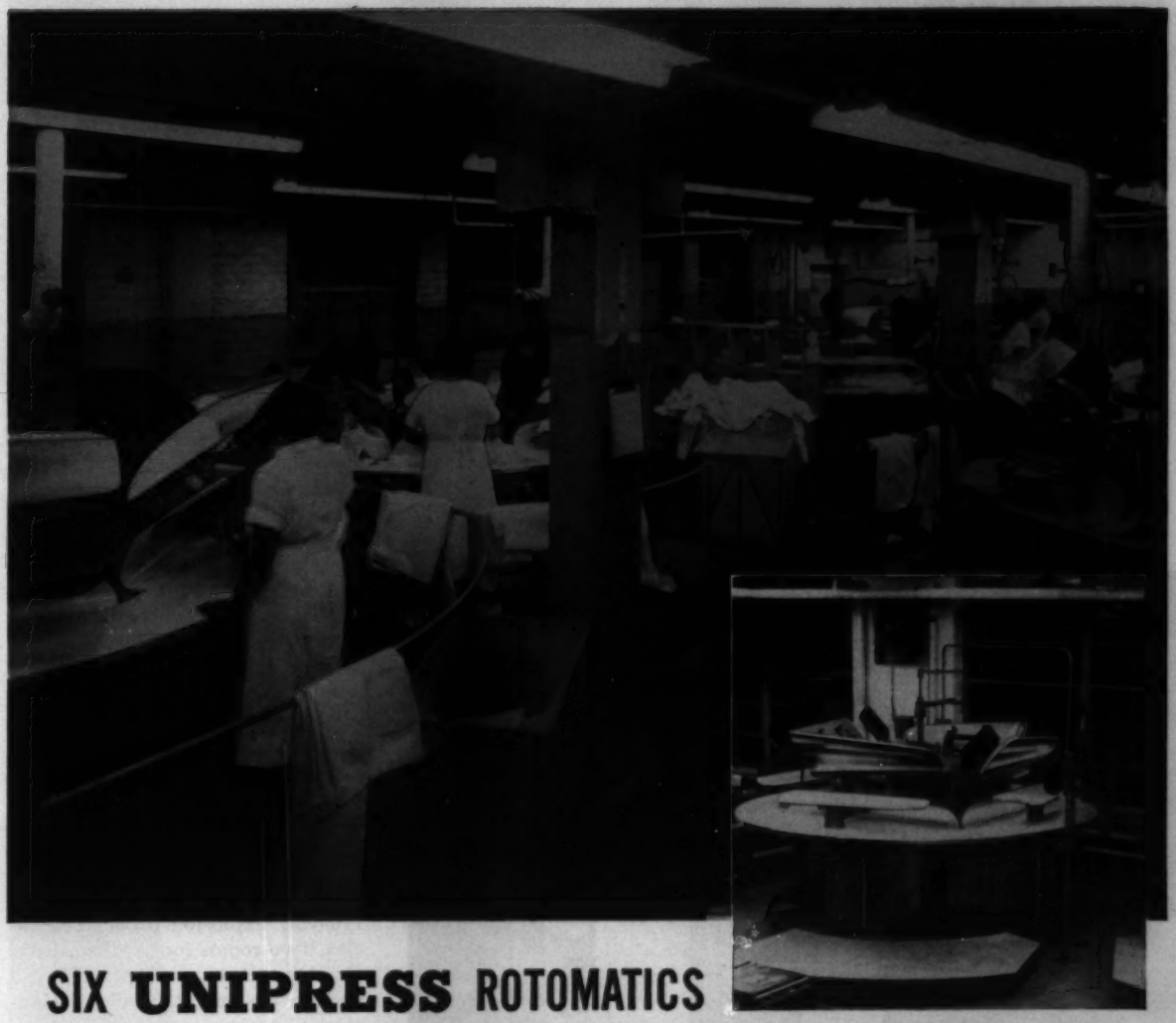
At the service entrance is a patient transfer alcove (11 by 16 ft.). Each patient is brought to the suite in his own bed. In this transfer alcove, he is transferred directly to the operating table. The bed is moved to the recovery room, where it remains to receive the patient brought from surgery on the operating table. This procedure reduces postoperative handling of patients to a single transfer, reduces the need for stretchers and for parking them, and eliminates need for special recovery room stretchers.

CENTER CORE

The center core of the major suite contains service space and facilities that are common to all surgeries. The control desk is equipped with a pneumatic tube that links the unit to all other hospital departments, and a two-way intercommunications unit, which links it to all surgery rooms, the recovery room, and the minor surgical suite.

The instrument room (20 by 24 ft.) is accessible from the control station and both corridors. Since all sterile and unsterile supplies except instruments are furnished by the central supply department (first floor), the entire area is devoted to storing, cleaning and sorting instruments. Pegboards with hooks hold all ringed instruments; flat instruments are stored in trays. Instruments are brought to this room after being cleaned in a washer-sterilizer. They are again sterilized in the high-speed sterilizer just before surgery.

An anesthesia storage and workroom (15 by 21 ft.) and a general equipment storage room (15 by 21 ft.) occupy the remaining center core space. The equipment storage room is used for extra portable equipment such as hypothermia machines, fracture tables and heart pumps. Four 30 amp. 220-volt receptacles are evenly distributed in



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THIS patient is being transferred from his own bed to the operating table in an alcove at the service entrance to the major surgical suite. The patient's bed will be moved to the recovery room to await his return from the surgery room.

the center core corridors for power source to portable x-ray and other equipment.

Each surgery room is provided with two panels of piped nitrous oxide, oxygen, medical compressed air and suction. These services are accessible to the operating table overhead through use of swinging suspension booms. Swing booms also bring connectors from electronic recording equipment to the operating table. Deep open stainless steel shelving provides space for packs. Shallow covered shelving provides for the smaller supply items.

The floor is covered with conductive ceramic tile. The walls are ceramic tile to a height of seven feet. Dual track lights are installed in all but two rooms. One room is designed with an overhead viewing gallery. Each room has a warming cabinet for sterile saline and water solution. All rooms are on emergency power. Each room has at least four surface-mounted x-ray view boxes, and at least six 110-volt explosion-proof receptacles. Two rooms for cardiovascular surgery each have twenty 110-volt and six 60-amp. 220-volt receptacles.

The operating rooms (20 by 21 ft.) are a little larger than is usual. A teaching hospital needs the extra size to provide for additional personnel and equipment occupying the room during surgery. Three of

THIS anesthesia work and storage room is centrally located to serve the entire surgical suite efficiently.

the author

L. S. Rambeck is administrator of the new 320-bed University Hospital at the University of Washington, Seattle. Although the hospital has been open less than a year, Mr. Rambeck has been associated with it since the planning stage (1954). However, the University of Washington was not new to Mr. Rambeck in 1954; he completed his undergraduate work there and also served for two years as business manager of the University's health sciences division.

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the rooms have been designed to permit closed-circuit television transmission to various classrooms and the auditorium.

RECORDING EQUIPMENT NEEDS

Many design features were included to meet the special teaching and research needs of this hospital. Among other things, extensive use of recording equipment during highly specialized surgery entails space, a generous electrical supply and room shielding. Four operating rooms have small enclosed lateral galleries to house complex electronic recording equipment. Two-way room-to-gallery intercommunication keeps the surgeons in direct touch with the monitor. These rooms and their galleries have been specially shielded to keep out the external high-frequency interference of television and FM radio, and internal 60-cycle interference.

Although the facilities are adequate to meet the current instrumentation usage, we hope that space, power circuiting, and design will accommodate the kind of special apparatus that will be needed in the next one or two decades.

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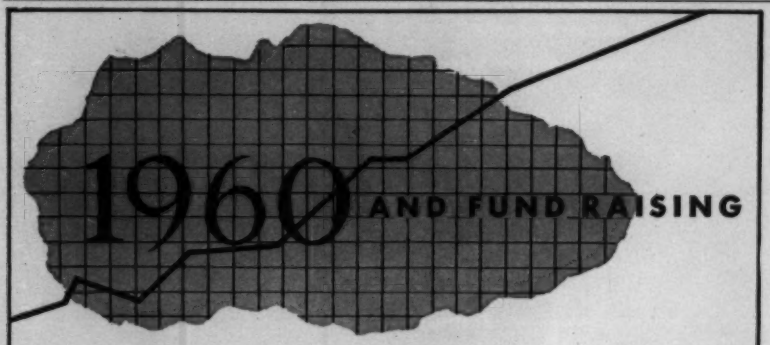
An isolated circuit panel is furnished at each operating room to provide isolated ungrounded circuits to the lighting equipment receptacles in the room. This serves to eliminate electrical spark discharges which could otherwise cause an explosion in the hazardous areas in the operating room. A green light indicates whether the system is operating satisfactorily; a red light and buzzer are activated whenever more than two milliamperes of current is flowing from any of the isolated circuit wiring to ground.

Lighting in the surgeries consists of three types; fluorescent, incandescent, and main operating lights. The three types furnish various degrees of intensities for the various types of operating room procedures.

The fluorescent lights have switches that provide two levels of illumination—50 and 25 foot-candles. Fixtures consist of recessed units with low-brightness diffusing panels. Standard 40-watt preheat lamps and ballasts are used to keep current leakage to ground at a minimum. The main operating room light in four rooms is equipped with a filament voltage control to furnish varying degrees of light intensity. Recessed incandescent fixtures with small wattage are provided to give a very low level path lighting when this is desired. One room has further special light control to produce light compatibility with color film in medical photography.

Ventilation and cooling in the surgical suite are accomplished by a complete and separate air conditioning system. Each room has individual room temperature control and shut-off provisions. The central air conditioning equipment for the surgical suite includes an electrostatic type filter, a renewable media filter, heating coils, cooling coils, and an air washer with dew-point control that maintains the supply of air to the surgery rooms at a relative humidity of 50 to 60 per cent. The relative humidity can be adjusted within this range at the central equipment. ■



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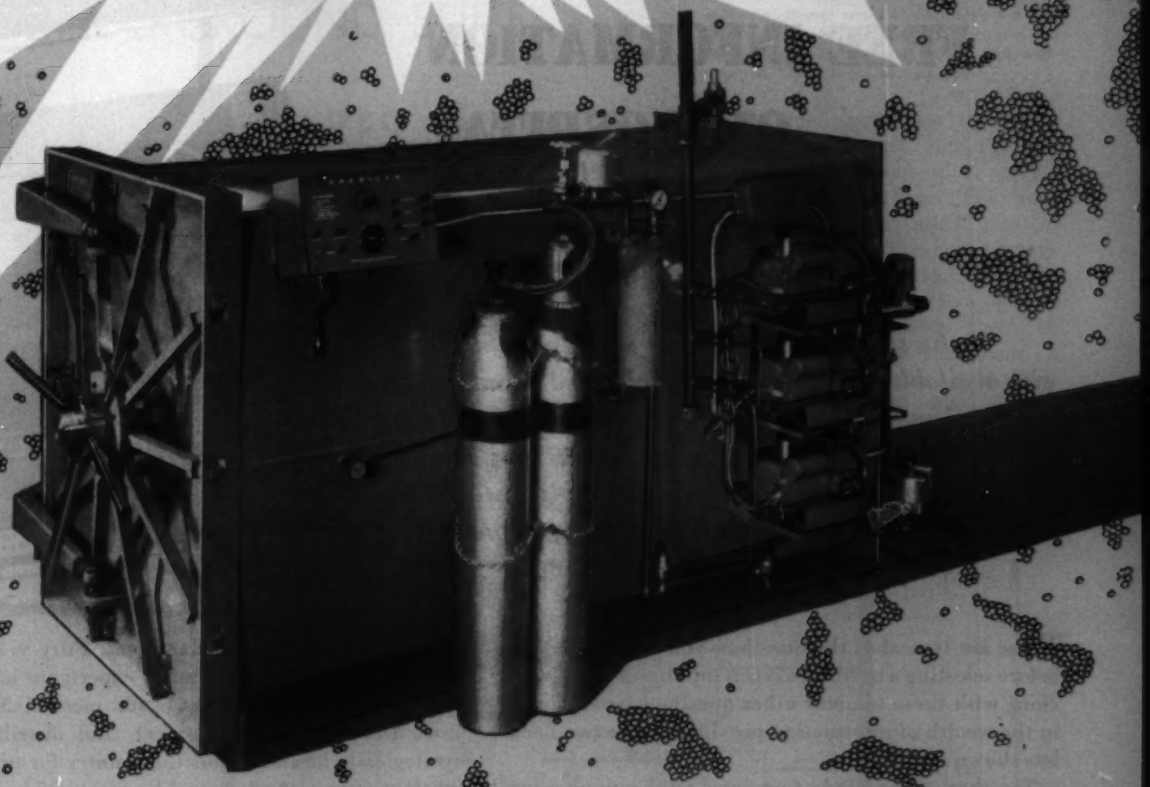

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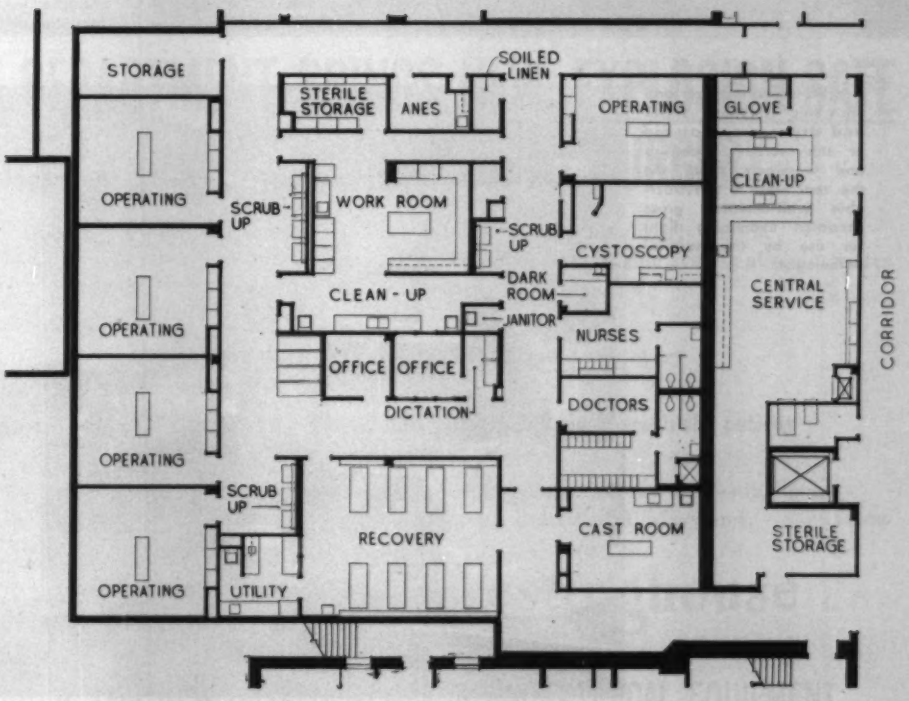
RECOVERY room patients can be easily observed from this combination nurses' station and utility room. A counter top refrigerator, medicine cabinet and clean-up area are provided in the station. The recovery room has oxygen and vacuum wall outlets and wall-mounted blood pressure apparatus.

THIS UNDERGROUND SUITE MAKES THE BEST OF A SPACE PROBLEM

by MRS. CECILE TRACY SPRY, R.N.

THROUGH INGENIOUS design, a completely new underground surgery department and central sterile supply service have been added to the General Hospital of Everett (Wash.). The new surgery department in this 155-bed hospital is equipped with five operating rooms, a cystoscopy room, an eight-bed recovery room and a cast room. The total gross floor area, approximately 8000 square feet, does not include the space



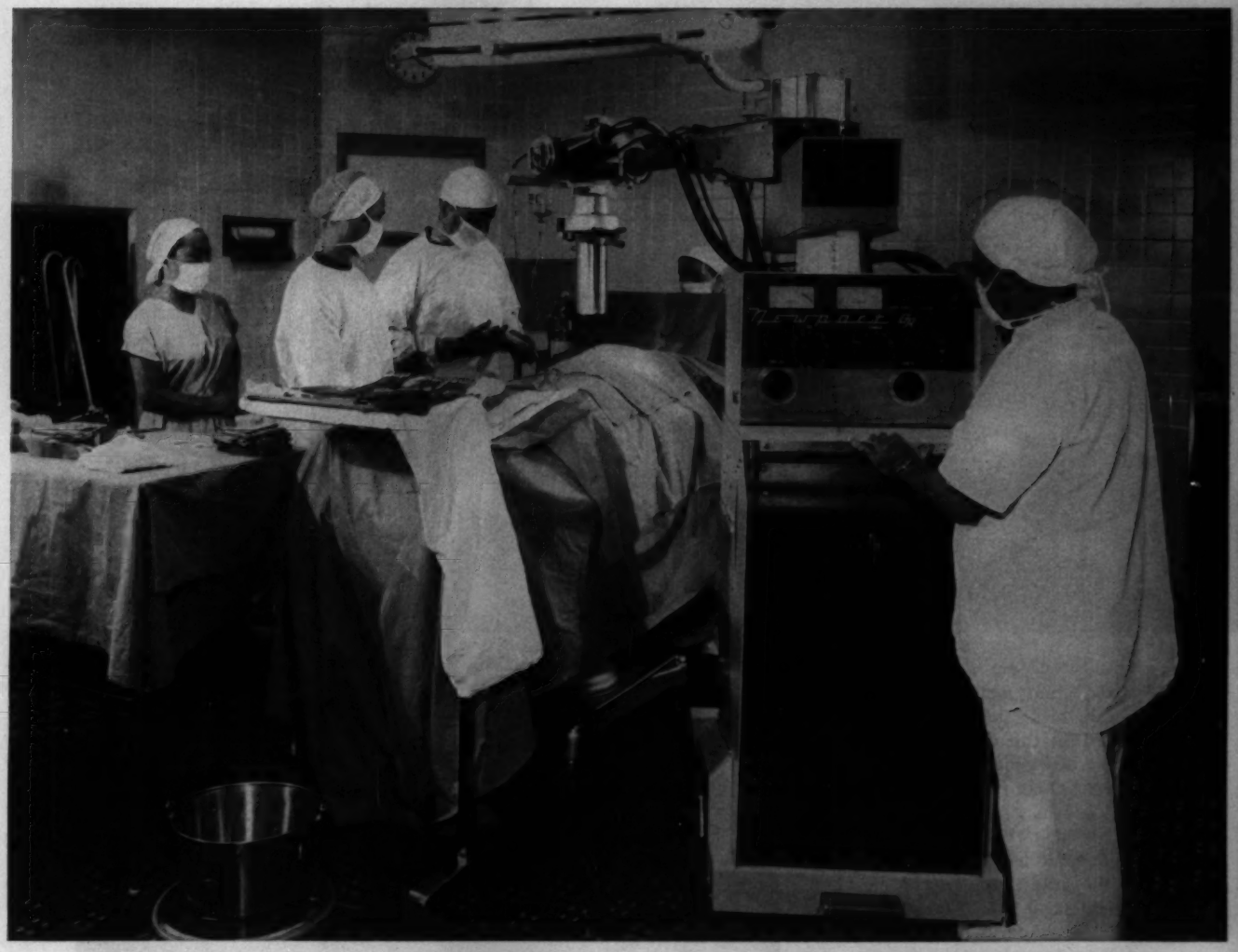
UNSTERILE instruments are stored on this convenient pegboard in the workroom area of the new surgical suite at the General Hospital of Everett (Wash.).

allowed for two additional surgery rooms to meet future needs.

It was recognized from the outset that the construction must be centered around the older main structure, since the new addition had to use the building's existing elevators. After considering several alternatives, the president of the board of trustees suggested that the new surgery department be built underground, with a physicians' parking area above. The

THIS partial view of the central service and sterile storage department shows the clean-up area in the foreground with the receiving entrance to the left. The dispensing door (not shown) is at far end of room.

A HIGH speed sterilizer and ultrasonic cleaner, rinser and dryer are featured in this surgery clean-up and workroom area. On the rear wall is a retractable wall-mounted gross specimen examining light for use by the hospital pathologist.



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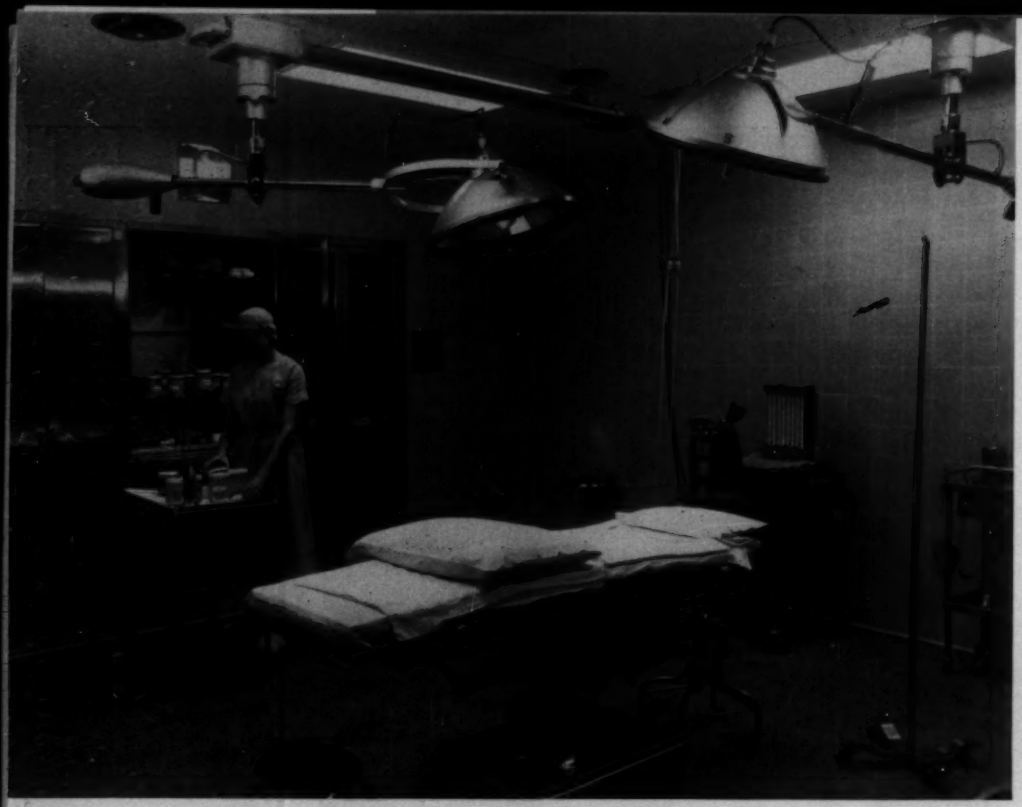

CEILING mounted oxygen, nitrous oxide, and vacuum outlets are provided in all five surgery rooms, and one room has a compressed air outlet. The operating room for urology procedures includes an x-ray film processing area and portable x-ray machine.

architect, John W. Maloney of Seattle, then made studies as to the feasibility of this suggestion.

Building the department below ground level did create problems, however. Three sides of the existing "H"-shaped building form a court which, combined with the street, limited the space available for the addition. Therefore, the surgical suite had to take a predetermined shape instead of a shape resulting from function. In spite of this limitation, the plan was made very functional by locating the workrooms in the center and surrounding them with operating rooms.

An outstanding feature of the

THE SURGICAL supervisor's office commands a window view of the clean-up and workroom area shown in the background. A pass-through window permits communication between areas.

the author

Mrs. Cecile Tracy Spry, R.N., entered the field of hospital administration from a career jn nursing. She served as superintendent of nurses and the school of nursing at the Tacoma (Wash.) General Hospital before her appointment as administrator of General Hospital of Everett, Wash., 30 years ago. A fellow of the American College of Hospital Administrators, Mrs. Spry currently serves as a member of the board of trustees, Washington Hospital Service, Seattle. She is a past president of the following groups: Association of Western Hospitals, Washington Hospital Association, Washington State Nurses Association and the Washington State Nurse Planning Council.

EVEN IN "SEEMINGLY HOPELESS CASES" INVOLVING "HOSPITAL STAPH"...

"It would appear, therefore, that from this limited experience with 17 desperately ill patients, parenteral novobiocin [Albamycin] is therapeutically effective and offers a reasonable expectation of a favorable response even in seemingly hopeless cases."

Garry, M. W.: Am. J. M. Sc. *236*:330 (Sept.) 1958.

"Staphylococcal sepsis, particularly as it appears within the hospital environment, continues to represent a serious and difficult therapeutic problem. . . . It would appear that novobiocin [Albamycin], like other broad-spectrum antimicrobial agents, will be of clinical value in a certain number of staphylococcal infections."

Colville, J. M.; Gale, H. H.; Cox, F., and Quinn, E. L.: Antibiotics Annual 1957-1958, p. 920.

The use of Albamycin has not been accompanied by systemic toxicity — renal, hepatic, or hematopoietic. Side effects (such as skin rash) have been minor in nature, and those that do occur are easily managed.[1-3]

1. Garry, M. W., *op. cit.* 2. Editorial, New England J. Med. *261*:152 (July 16) 1959. 3. Nunn, D. B., and Parker, E. F.: Am. Surgeon *24*:361 (May) 1958.

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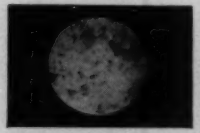
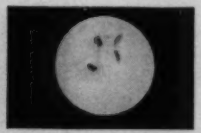


BEFORE! Micro-photograph shows typical bacteria found on bathroom sinks.



AFTER! Lab tests show conclusively COMET disinfects as it cleans!

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suite location is its convenient proximity to other services. A maximum of 160 feet separate the surgery department from the emergency rooms, the radiology and pathology departments, and the central sterile supply service. Equally as close are the laboratory, two elevators, cafeteria and physicians' parking area. Functionally, one could ask for little more.

The surgery suite is completely air conditioned; fresh air is electrostatically cleaned, filtered, preheated and humidified. Each operating room has its own temperature and humidity control, speaker grille for piped-in music, ceiling mounted oxygen, nitrous oxide and vacuum outlets. One surgery room is provided with compressed air.

Piped-in music is one of many desirable features of the recovery room. This room has wall-mounted blood pressure apparatuses and two stainless steel work shelves that keep the floor and beds free of objects. The adjoining combination nursing station and utility room has a large window for easy viewing of patients.

Careful planning has made the cast room extremely versatile. Equipped like the other surgeries, it is located just outside the surgery suite. Its proximity to the emergency entrance makes it ideal for accommodating outpatients and serving as a third emergency room when needed.

In the workroom area, instruments are processed in an ultrasonic cleaner and dryer. Instrument packs are made up in surgery and sterilized in the central sterile supply service. All other items are both wrapped and sterilized in the central service.

A feature much appreciated by physicians is the dictating area provided for them next to the surgical supervisor's office. On the other side of the office is a conference room for teaching student nurses.

Pleasant working conditions prevail in this underground surgical suite. The generous use of yellow ceramic tile in the corridors and work areas, good lighting and acoustical ceilings have overcome any feeling of being closed in. Even during the busiest hours, the suite is quiet. ■

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food service and dietet

SECOND OF TWO ARTICLES

GOOD HOT FOOD IS NOT ENOUGH

PERSONNEL who deliver trays can "make" or "break" mealtime for the patient. Personnel who are attired in clean, neatly pressed uniforms and who have a pleasant greeting for the patient can help patients approach mealtime positively.

SERVICE of good hot food is not enough to please patients; trays need to be so attractive that they will tempt even the most reluctant.

by J. W. BLOCH

ALTHOUGH FOOD service has remarkably improved in many hospitals during the last 15 years, some patients still complain about their food. "It's cold." "It's tasteless." "The menus are too repetitive." These are the most frequent complaints. On the surface it would appear that just by serving good tasty food—and by serving it hot—hospitals would satisfy many patients' complaints. By doing this economically, moreover, food service directors would satisfy many hospital administrators.

Unfortunately, even when a meal has been correctly planned and skillfully prepared, it is often cold when it reaches the patient. Instead of providing anticipated dining pleasure for the patient, mealtime becomes a disappointment for him.

Serving good hot food in the hospital is a considerable achievement, but it is not enough. Food service in a hospital is part of the total pattern of patient care. It is a paramedical function designed to assist the physician by providing the proper diet.

In simplified terms, hospital food service has three major functions:

1. Interpreting physicians' prescriptions for patients' diets and converting them into definitive menus.

2. Producing meals for patients, personnel and staff in accordance with firmly established principles of cookery.

3. Establishing controls to insure an economical and efficient operation.

To these functions must be added the myriad of auxiliary, but nevertheless vital functions to round out the framework of satisfactory hospital food service. These auxiliary functions include patient visiting, purchasing, recipe standardization, storeroom control, pre-preparation, cooking, serving, personnel training, cleaning, sanitation, maintenance, follow-up of complaints, cost accounting, etc.

From this listing of functions, it is evident that hospital food service is very complex. In fact, it has become so involved that the dietary staffs of many larger hospitals employ both professionally qualified dietitians and persons with restaurant or hotel experience.

In this type of dietary department organization, the question frequently arises who should supervise whom in the table of organization. The answer is simple; it should be the person best qualified by reason of past experience, personality, education and qualities of leadership, whether it is the dietitian or the food service manager.

The author believes that it is

In the second of two articles on providing more than good hot food, the assistant to the director of Montefiore Hospital, New York, who is in charge of the hospital's food service, outlines the hospital's program for achieving patient satisfaction with food service. The program calls for division of responsibility between the food service manager and the dietitian in the operation of the dietary department.

In the first article, in the March 1 issue of this Journal, the chief dietitian at the Greenwich (Conn.) Hospital detailed a similar program for achieving patient satisfaction that features coordination of all dietary services under the chief dietitian.

J. W. Bloch is assistant to the director of Montefiore Hospital, New York, and is in charge of the hospital's food service. This article is an adaptation of the author's address at the 61st Annual Meeting of the American Hospital Association, August 1959.

difficult for one person to handle all aspects of food administration in a large modern hospital. It takes a minimum of 5 to 10 years for a dietitian to become thoroughly proficient in the field of therapeutic dietetics with all its ramifications into medicine, physics, chemistry and physiology. The dietitian also needs to master the techniques of interviewing patients and of supervising personnel. It takes time to acquire the right amount of tact and diplomacy and to learn how to put dietary theory into practice.

It takes a number of years for a person trained in hotel or restaurant administration to master the fields of quantity cookery and meat cutting. It takes years of experience to be able to recognize good quality in different types and grades of foods; to acquire knowledge of kitchen and equipment layouts, scheduling of food production and personnel, budgeting, techniques for orienting and training personnel, cost accounting, controls in food purchasing, production and service; and finally, to learn how to adapt commercial food production experience to hospital food service.

In addition, the dietitian and food service manager must each spend a great amount of time keeping abreast of new developments. They must read pertinent technical literature, attend conferences, and implement new concepts of diet therapy and food management into dietary operation.

DIVISION OF RESPONSIBILITY

The dietary department actually could be divided into two areas of operation, or better, of cooperation. One would involve the medical aspects of food service or the therapeutic areas of food utilization. The other would be devoted mainly to the nonmedical and administrative aspects of food service.

Between these two areas lies a vast territory of shared and frequently overlapping responsibilities, such as menu planning, simplification and standardization of recipes and service, personnel supervision and policy administration. These shared areas of responsibility make it difficult to draw a clear line of delineation of responsibility for the dietitian and food service manager.

The author believes that good hot food, served in a pleasing, efficient and economical manner, is sufficient for service of normal diets, providing these diets meet the recommended dietary allowances. However, for modified or "special" diets, it takes the skill and knowledge of a dietitian to plan the menus in light of the physician's prescription and the patient's food likes and dislikes.

The dietitian is also needed for nutrition research and for teaching other dietitians and physicians current and new thinking in diet therapy. The dietitian must also teach patients, personnel, staff, student nurses and medical students the requirements for normal as well as modified diets.

On the other hand, the person with restaurant or hotel administration background is needed to maintain the dietary department on a sound operational basis. What is needed here is a person who knows what a case of eggs should weigh, can recognize good quality food products, knows the yield of

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FRANK C. MASSEY, Administrator
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PAPER
the personal food service

food products and how best to utilize them, has good business sense, understands cost percentages, knows kitchen layouts, and has administrative talents. This does not mean that a dietitian cannot acquire these skills. But in a large, complicated food service operation, it is best to divide these areas between two persons.

In the author's opinion, there is no conflict of interest between the professionally qualified dietitian and the commercially trained food administrator. There is need for both. They must work together; they must help each other, they must supplement one another's knowledge.

NEEDED AREAS FOR RESEARCH

There are many ways in which the combined talents of the dietitian and food service manager can be utilized to improve hospital food service. One area where this would be particularly true is modified diets. Too little research has been done on making "special" diets more acceptable to the patient.

Fortunately, the literature indicates that some research has been conducted in this regard. In 1954 the *Journal of the American Dietetic Association* had six articles on the use of spices in preparation of "special" diet foods.[1, 2] For example, salt-free mashed potatoes were made more palatable by the addition of a dash of nutmeg. Other flavorings could be imparted to certain foods by the use of herbs, wine, lemon juice and different extracts. Yet, these suggestions are only a faltering step in the right direction.

The soft diet is another modified diet where much research needs to be done. There is definitely a need to make pureed fruits and vegetables more eye-appealing and appetizing. Perhaps some study of how to serve these pureed foods would be helpful. More emphasis should be placed on serving colorful combinations and enhancing their appearance by the addition of garnishes and other decorations.

Everyone knows how the labels on cans of strained baby foods are attractively displayed on the grocery shelf. Perhaps some appetizing pictures in color of the original appearance of the foods could be conspicuously added to the tray to enhance the patient's appetite.

Perhaps a study could also be made of the various containers used for the serving of pureed foods. Montefiore Hospital now serves pureed foods in bouillon cups, or in bowls made of china, pyrex, paper, plastic, aluminum foil, or a combination thereof. The author is hopeful that new shapes, new materials and especially new colors for serving containers will be further explored.

OTHER FACTORS FOR CONSIDERATION

In addition to service of good hot food and establishment of an efficient organizational structure, there are still other factors to be considered in operating a food service department.

An attractive tray is very important. Everything should be immaculately clean. The glassware should be sparkling and the silver shining. The napkin should be of proper size. Everything that the menu calls for should be included.

Another important factor in hospital food service operation is the person serving the tray to the patient. This person should be properly trained to be friendly, smiling and courteous. She should say a pleasant "good morning" or "good evening". She should also ask the patient if everything is satisfactory. Perhaps she should also add a few words about how attractive the tray looks in order to make the patient feel more at home.

Patients are full of anxiety and look forward to mealtime as something enjoyable. If the personnel who serve them look untidy, mealtime may prove a disappointment for the patient. Personnel who serve trays should wear well ironed uniforms and have shined shoes and well groomed hair at all times. This makes for a better atmosphere and undoubtedly the food will taste better to the patient.

The author hopes that hospital food service will continue to improve as the result of the joint efforts of professionally qualified dietitians and food service managers and that some day we may talk of "hospital gastronomy". ■

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1. Herbs and spices for low sodium diets. *J. Am. Diet. A.* 30:452 May 1954.
2. Cantoni, M. Adding flavor to sodium restricted meals in the hospital. *J. Am. Diet. A.* 30:1146 Nov. 1954.

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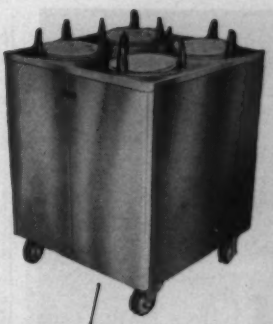

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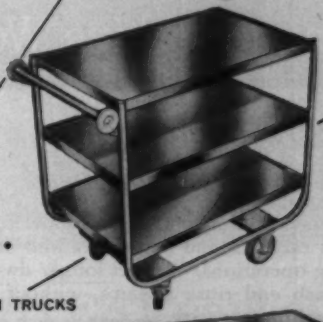
TRAY LIFTERS



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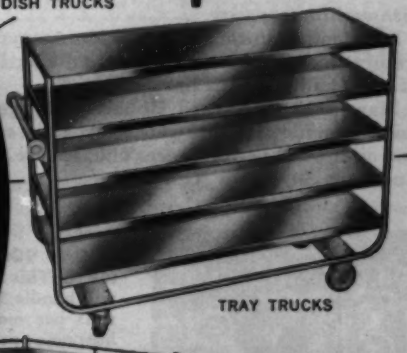

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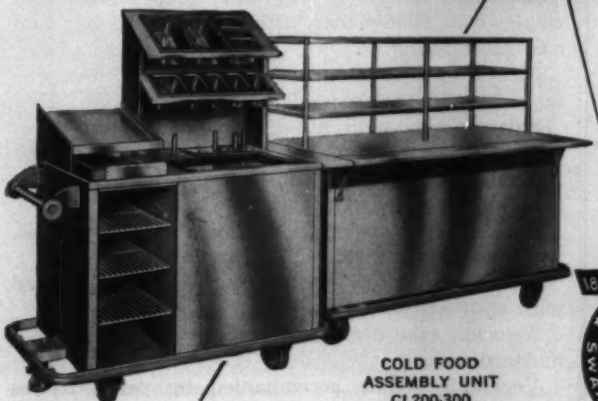

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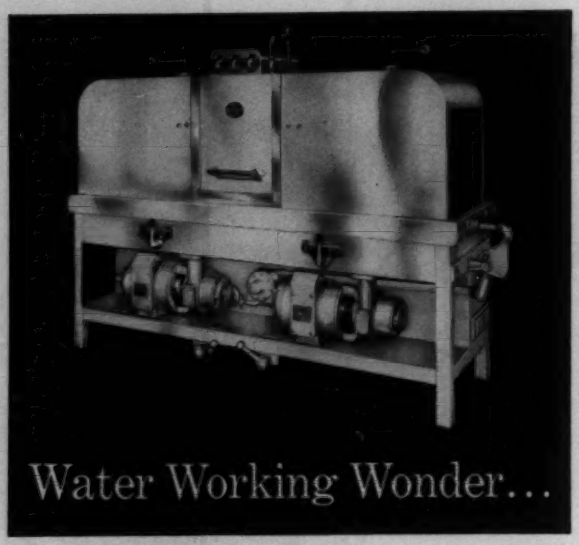

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MAKING MEATLESS MEALS MEMORABLE

When meat is deleted from hospital trays and personnel menus because of diagnostic procedures or religious custom, the dietitian is faced with the problem of providing good, satisfying and inspirational substitutes without meat. Moreover, the substituted items must convince patients and personnel that a meal without meat is not like apple pie without cheese.

The following menu suggestions offered by Ilma Lucas Dolan of the California Foods Research Institute in San Francisco may be of help in planning meatless entrees that are colorful to look at and satisfying to eat.

Cream of tomato or vegetable soup served with wholewheat sandwiches with hard-cooked egg and ripe olive filling.

Clear soup with avocado "floats", served with open-faced broiled tomato and cheese sandwiches.

Shirred eggs with hot tiny canned green beans vinaigrette.

Omelet with Spanish, shrimp or asparagus sauce and cabbage slaw with raisins.

Goldenrod eggs served on broiled sliced tomatoes.

Cheese fondue with steamed parsleyed rice.

Welsh rarebit on toasted English muffin, served with scalloped tomatoes.

Assorted cheese plate with green beans in a hot mustard sauce.

Vegetable souffle accompanied by peach halves filled with grated cheese and mayonnaise and broiled.

Vegetable pie with quartered hard-cooked eggs, served with canned cling peach halves filled with chutney.

CONTINENTAL SUPPER PIE earns a four-star rating as a meatless entree. Sauteed sliced onions, eggs, commercial sour cream, seasonings, and ripe olives are baked in a pastry-lined pan until set. The hot entree is served in wedges with carrots and cauliflower.

Continental Supper Pie served with waffle-sliced carrots and parsleyed cauliflower. (See photo on facing page).

Chef's salad with Julienne strips of cheese, slices of avocado, whole pitted ripe olives.

Baked spinach Parmesan with baked potato and squash. (See photo at bottom of page).

Fresh fruit salad with cottage cheese, citrus segments, fresh dates, marshmallows, toasted almonds and hot French rolls.

Calavo avocado half shells filled with cottage cheese or egg salad.

Spanish Calavo avocado half shell filled with hot tomato-seafood sauce. (See photo below).

SPANISH CALAVO AVOCADO features a tomato sauce, seasonings, and finely chopped celery which have been heated to boiling before seafood or hard-cooked eggs are added. The mixture is then ladled into half shells of avocado. The semitropical fruit (which is in abundance this year) and the seafood are then baked in a moderately hot oven for approximately 15 minutes.

BAKED SPINACH PARMESAN makes it easy for patients and personnel to forget about meat. It is served with baked potato and squash. To prepare the entree, chopped cooked spinach is combined with eggs, bread, instant minced onion, other seasonings and grated Parmesan cheese and is baked until set. It is served with a tasty sauce which has been accented with American cheese and sharpened by the addition of worcestershire sauce.

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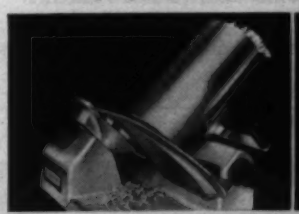

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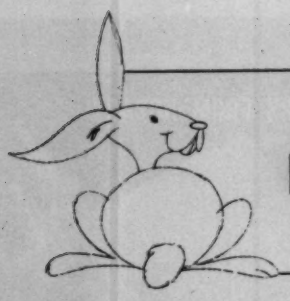

Easter Sunday Menu Inserts

SUGGESTIONS for adding festive notes to Easter menus are presented below in a separate holiday menu for the Midwest, South-Southwest, East and North-Northwest.

These holiday menus have been prepared by the authors of the AHA spring cycle menus to key in with the spring cycle menu series. Spring cycle menus were published in the January and February issues of the Journal.

On Easter, the menus below may be used in place of the menu from the AHA spring cycle menu series that would have been used on April 17.

If these substitutions are made, the appropriate weekly market order for perishables should be checked for deletion of items for the April 17 scheduled menu and substitution of items needed to produce these suggested menus.

Since one of the choices offered on the Easter Sunday menus is designed for use on modified diets, the menus can be used for both normal and modified diets.

In addition to providing a selective menu for Easter Sunday, the authors are sharing their recipes for some of the items. The recipes follow.

EASTER CITRUS SALAD WITH MAYONNAISE

(25 servings)

4 white grapefruit
4 pink grapefruit
2 lbs. cream cheese
4 heads lettuce or endive
¼ bunch parsley
1 c. mayonnaise
Red, yellow and green food coloring

1. Peel and section grapefruit.
2. Cream the cheese and divide

EASTER SUNDAY MENU INSERTS FOR THE MIDWEST, SOUTH-SOUTHWEST, EAST AND NORTH-NORTHWEST

	breakfast	noon	night
Midwest	Strawberries over Chunk Pineapple (F) or Blended Citrus and Apricot Juice (S) Farina or Cornflakes Poached Egg—Broiled Bacon Cinnamon Roll	Consomme with Fresh Parsley Baked Ham with Raisin Sauce (F) or Roast Leg of Lamb with Mint Jelly (S) New Potatoes in Cream Sauce (FS) Broccoli Hollandaise (F) or Buttered Tiny Beets (S) *Easter Citrus Salad with Mayonnaise or Spring Garden Salad with Roquefort Cheese Dressing Pink Mint Ice Cream (F) or Angel Food Cake (S)	Cream of Vegetable Soup Chicken Salad with Blueberry Muffin (F) or Toasted Cheese Sandwich (S) Stuffed Baked Potato (FS) Buttered Fresh Asparagus (FS) or Frozen Peas in Cream Head Lettuce or Fruited Cherry Gelatin Salad with Mayonnaise White Nectar Peaches (FS) or Lemon Sponge Pudding
South-Southwest	Rainbow Citrus Sections (F) or Applesauce (S) Whole-Wheat Cereal or Ready-to-Eat Sugar Coated Cereal Grilled Canadian Bacon—Soft Cooked Egg Hot Cross Buns (F)—Apple Jelly	Seafood Cocktail with Sauce and Lemon Wedge (F) or Barley-Beef Soup—Crackers (S) Glazed Southern Baked Ham with Raisin Sauce (F) or Roast Cornish Game Hen—Wild Rice Dressing (S) Creamed New Potatoes and Peas (F) or Baked Yam (S) Buttered Tiny Whole Onions (F) or Fresh Asparagus Spears with Hollandaise Sauce (S) *Spring Relish Salad or Jellied Fruit Salad with Mayonnaise *Peter Rabbit Cake (FS) or Fresh Strawberries	Fresh Vegetable Soup (F) or Chicken Broth—Crackers (S) Toasted Club Sandwich (F) or Broiled French Lamb Chop—Mint Jelly (S) Baked Potato (S) Buttered Green Beans (F) or Mashed Yellow Squash (S) Pear Salad with Cream Cheese Ball or Pickled Beet Salad—Mayonnaise Tropical Fruit Float (F) or Easter Brick Ice Cream with Bunny Cookie (S)
East	Half Grapefruit, Green Cherry Garnish or Orange Juice (S) Oatmeal or Cornflakes (S) Scrambled Eggs (FS) Hot Cross Buns (F)	Pineapple Juice—Sesame Crackers Glazed Baked Ham—Whipped Horseradish Sauce (F) or Roast Leg of Lamb, Currant Jelly (S) Parsley New Potatoes (FS) Buttered Fresh Asparagus or Buttered Julienne Carrots (FS) Gingerale Salad or Lettuce Hearts—Roquefort Cheese Dressing *Easter Cupcake (F) or Lemon Sherbet (S)	Consomme—Lemon Slice Garnish Chicken a la King on Crisp Noodles or Cheese Souffle (FS) Cloverleaf Roll (FS) Mashed Squash (FS) or Buttered Green Beans Spring Salad or Deviled Egg Salad Easter Sugar Cookies—Vanilla Ice Cream (FS) or Fresh Fruit Cup
North-Northwest	Strawberry-Rhubarb Sauce (F) or Pear Nectar Rice Farina with Raisins (F) or Ready-to-Eat Sugar Coated Cereal Bacon Omelet Hot Cross Buns (F)	Orange Sherbet Punch Fruit Baked Ham with Sliced Egg Garnish (F) or Crab Souffle (S) Baked Yams (F) or Steamed Rice (S) Buttered Fresh Asparagus or Buttered Spinach (FS) Relish Plate or Blended Vegetable Juice and Cottage Cheese Aspic Bunny Basket Cupcake (F) or Easter Ice Cream Slice (S)	French Onion Soup (F) Cube Steak or Chicken-Mushroom Casserole (FS) French Fried Potatoes or Parker House Rolls (FS) Creamed Peas (FS) or Parsleyed Carrot Rings Fresh Vegetable Bowl with Blue Cheese Dressing or Spiced Peach on Lettuce Chocolate Cream (FS) or Fresh Fruit Cup

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet Bread, butter and a choice of beverages are to be included with each meal.

*Recipe and photograph of this item are included immediately following the menus.

Midwest Easter Sunday menu was prepared by Lottie Crecelius, chief dietitian, Memorial Hospital of Springfield, Ill.

South-Southwest Easter Sunday menu was prepared by Laura Robeson, director of food services, Presbyterian Intercommunity Hospital, Whittier, Calif.

East Easter Sunday Menu was prepared by G. Gwendolyn Taylor, director of dietetics, Strong Memorial Hospital, Rochester, N. Y.

North-Northwest Easter Sunday menu was prepared by Norma M. MacRae, consultant dietitian, Medical and Dental Building Hospital, Seattle.

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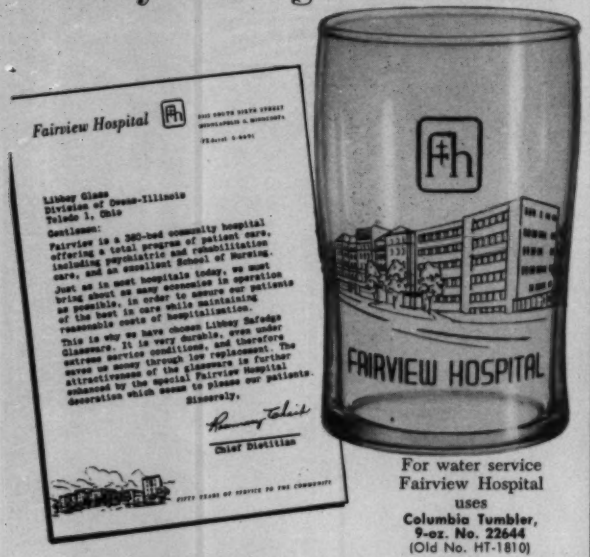
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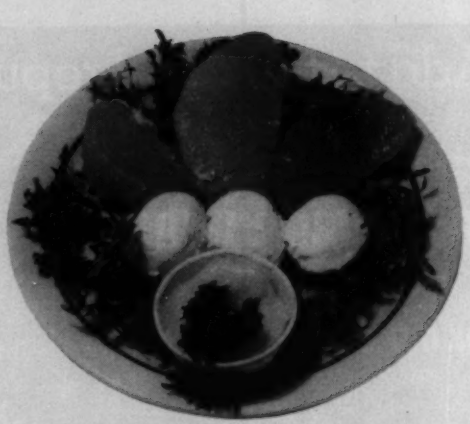


EASTER CITRUS SALAD WITH MAYONNAISE

into three parts and color with pink, yellow and green tints. Mold cheese into small Easter eggs.

3. Arrange grapefruit sections in fan shape on bed of lettuce or endive and place one cheese egg of each color at base of grapefruit sections.

4. Serve with mayonnaise and garnish with parsley.

NOTE: The half-blanched leaves of head lettuce make an attractive over-all pastel tinted salad, whereas the endive base is more striking for photographic purposes.

SPRING RELISH SALAD

1. For each serving of spring relish salad, place a

SPRING RELISH SALAD

ring of plain green gelatin on lettuce leaf or bed of endive.

2. Fill the center of the gelatin ring with mayonnaise or cottage cheese and top with one-half of hard-cooked egg.

3. Carrot curls and radish roses are used for garnish.

PETER RABBIT CAKE
(25 servings)

1. Prepare 1½ pans (18 by 24 inches) of thin white sheet cakes.

2. Twenty-five pieces of cake are cut from one pan and the remaining one-half pan is used for the tapered strips of cake that are used to form the rabbits' ears.

PETER RABBIT CAKE

3. The faces and ears of the rabbit cakes are iced with a powdered sugar icing that has been made from 2 lbs. powdered sugar.

4. Ears and whiskers are colored by use of a wet knife dipped in paprika.

5. Jelly beans are used for the rabbit's eyes and nose and red ornamental candy or icing for his bow tie.

EASTER CUPCAKES

1. Prepare the required number of cupcakes from white, chocolate or angel cake mix, according to the instructions on the packages.

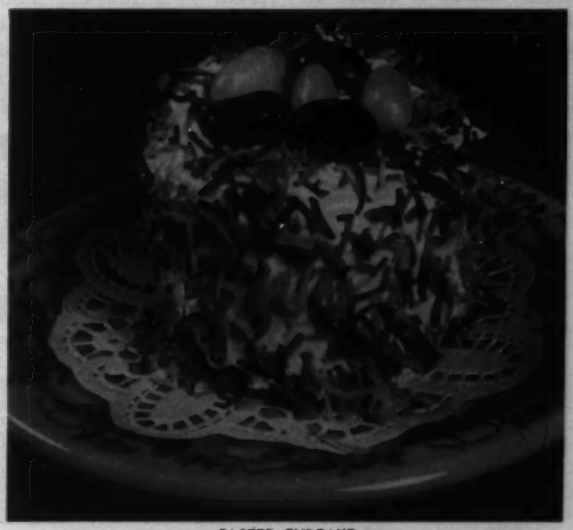
2. Ice the cupcakes with a white boiled frosting. Frost the sides of the cupcakes first, building up an edge on top to form a nest.

3. Sprinkle the sides and top of cupcakes with toasted coconut.

4. Place a few small, candy, Easter eggs in the "nest".

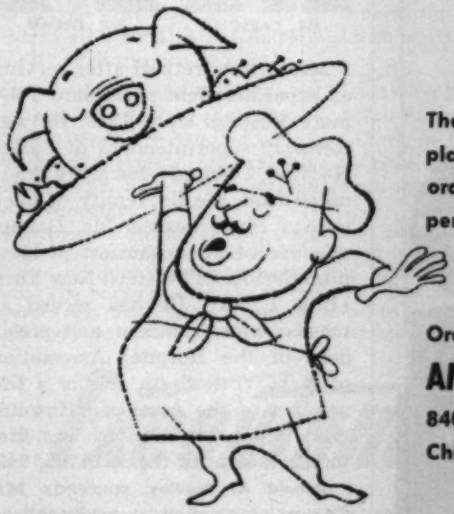
5. Serve on plate with lace doily.

NOTE: To toast coconut, heat oven to approximately 350°F. Spread coconut in shallow pan. Bake until toasted, stirring occasionally. Baking time is approximately 8-10 minutes.



EASTER CUPCAKE

NEED MENU PLANNING IDEAS?



The *Hospital Food Service Manual* provides details of menu planning as well as information on preparation of food orders, purchasing, storage and service, care of equipment, personnel and accounting. 1954. 306 pages.

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personnel changes

● **O. Wade Avant Jr.,** an administrative assistant for the past year at North Carolina Baptist Hospital, Winston-Salem, has been named administrator of Barnwell County Hospital, Barnwell, S.C. He succeeds **Charles C. Boone.** Mr. Avant has a master's degree in hospital administration from Yale University. Mr. Boone has been appointed one of two superintendents at Duke Hospital, Durham, N.C. He succeeds Dewitt Wright, who died last August. Mr. Boone is a graduate of Duke University's program in hospital administration. He is a past president of the South Carolina Hospital Association.

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● **Paul E. Bourquin,** who has been controller of Lankenau Hospital, Philadelphia, is now assistant director and controller. **Harold W. Maysent,** who served as assistant director since 1955, has been promoted to associate director of the hospital.

● **Donald A. Bradley** (see Leon C. Carson item).

● **Joe B. Carmical** (see McCuistion item).

● **Leon C. Carson** has been appointed superintendent of Millard Fillmore Hospital, Buffalo N.Y., succeeding **Harold A. Grimm.**

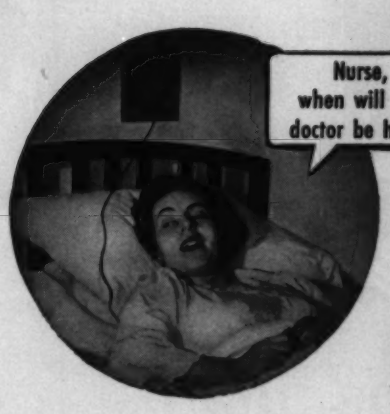
Mr. Carson formerly served as assistant superintendent at the hospital. Before that he held two positions of administrative assistant, one at Robert Packer Hospital, Sayre, Pa., and the other at Citizens General Hospital, New Kensington, Pa. He is a graduate of the University of Rochester, and of the Columbia University program in hospital administration.

MR. CARSON

MR. GRIMM

Mr. Grimm retired after serving as superintendent of Millard Fillmore Hospital since 1930. He was formerly superintendent of Finley Hospital, Dubuque, Iowa. He graduated from the University of Iowa with a Ph.C. degree. Mr. Grimm was one of the organizers of Hospital Service of Western New York (Blue Cross). He has served as trustee, vice president and president of the Hospital Association of New York State and is a life member of the American Hospital Association. Mr. Grimm was first vice president of the AHA in 1945.

Donald A. Bradley succeeds Mr. Carson as assistant superintendent



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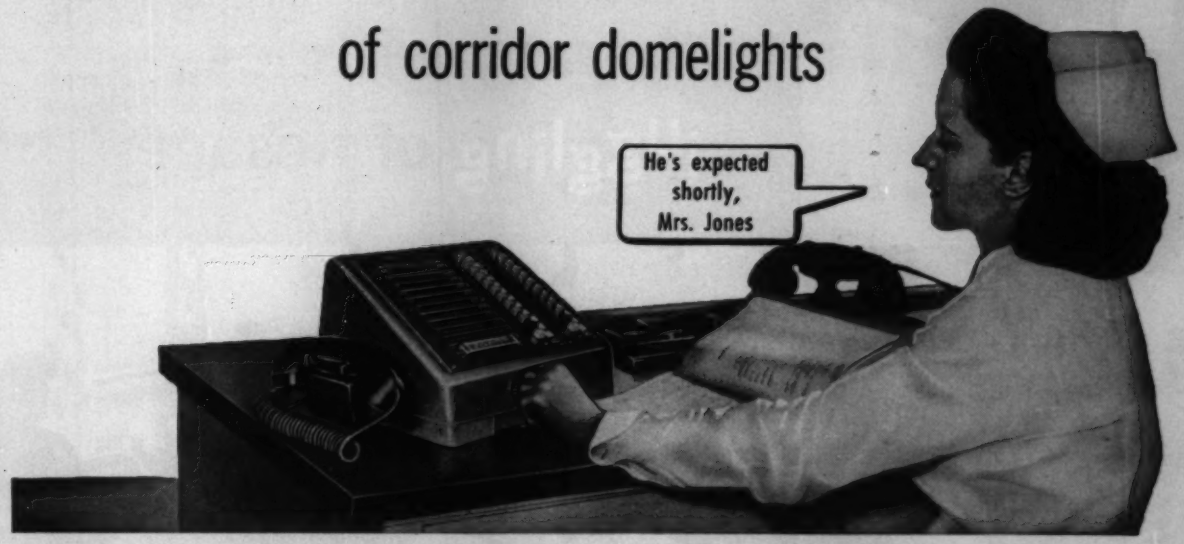

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By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply . . . Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

Just off the press!

"Better Patient Care"

How Executone communications help hospitals improve patient care and make maximum use of nursing time and skills. Includes a summary of time and motion studies of Executone Audio-Visual Nurse Call Systems made by the Surgeon Generals' offices of the Army and Air Force. Also described and illustrated are Doctors' Paging Systems, Bedside Radio-Sound Systems, Departmental Administrative Systems. Send in the coupon below for your complimentary copy.

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Without obligation, please send me a complimentary copy of "Better Patient Care."

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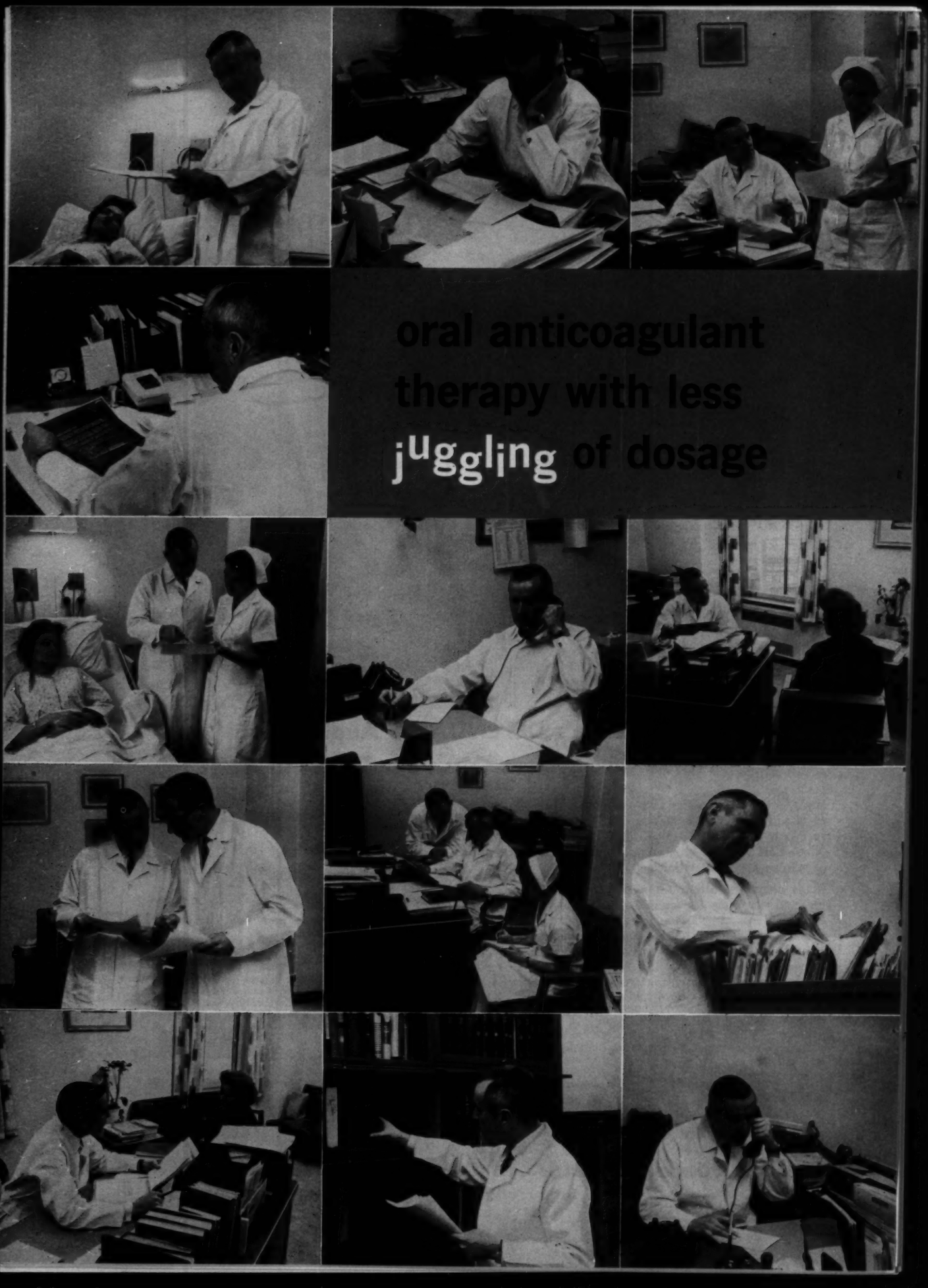
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therapy with less
juggling of dosage

introducing

PANWARFIN™

(Warfarin Sodium, Abbott)

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The physician's great advantage with PANWARFIN is this: *he can establish stable oral dosage with relative simplicity.*

PANWARFIN is predictable in its effect. The physician will note but little day-to-day fluctuation in his patients' prothrombin times. He isn't beset by the usual need for frequently readjusting dosage. Guided by simple lab determinations, he gains early control of coagulability, and maintains the dosage with a minimum of tinkering.

The initial dose provides therapeutic prothrombin levels within about 18 hours. Or, if *immediate* effect is desired, PANHEPRIN™ (Heparin Sodium, Abbott) may be given intravenously at the same time; after 24 hours, hypoprothrombinemia is then maintained by regular oral doses of PANWARFIN alone.

Consider PANWARFIN for your future anticoagulant regimens, doctor. Our literature gives full details. Ask your Abbott representative for it, or write.

SUPPLIED in 5-mg. white grooved tablets, List No. 6973, bottles of 100 and 1000; 10-mg. yellow grooved tablets, List No. 6988, bottles of 100 and 1000; and 25-mg. orange grooved tablets, List No. 6994, bottles of 25, 100, and 1000.

ABBOTT LABORATORIES NORTH CHICAGO, ILL.

603212

at Millard Fillmore Hospital. He was formerly administrative assistant of Ellis Hospital, Schenectady, N.Y. He is a graduate of Amherst College and the Columbia University program in hospital administration.

● **Pauline Churchill, R.N.,** has been appointed administrator of Harrison County Hospital. She was for the past three years at Our Lady of Mercy Hospital, Owensboro, Ky. Mrs. Churchill is a graduate of the Nazareth School of Nursing, Louisville, Ky.

● **John H. Daniels Jr.** has been appointed acting director of North Shore Hospital, Manhasset, Long Island, N.Y. He had been assistant director at that hospital since 1955. Mr. Daniels, a graduate of the University of Minnesota course in hospital administration, replaces **George W. Dana, M.D.,** who resigned recently to accept the post of executive director of the Southwestern Medical Foundation, Dallas.

● **Samuel Davis** has been appointed assistant administrator of Hillsdale Hospital, New York City. Mr. Davis holds a master's degree in hospital administration from Columbia University. He was formerly administrative assistant and director of ambulatory service at Roosevelt Hospital, New York City.

● **R. C. Eaton, M.D.,** has been appointed superintendent of South Florida State Hospital, Hollywood. He was formerly chief of service and clinical director at the Florida State Hospital, Chattahoochee, Fla., and before that superintendent, Provincial Hospital, Campbellton, New Brunswick, Canada. Dr. Eaton received his M.D. degree in Canada at Dalhousie University, Halifax.

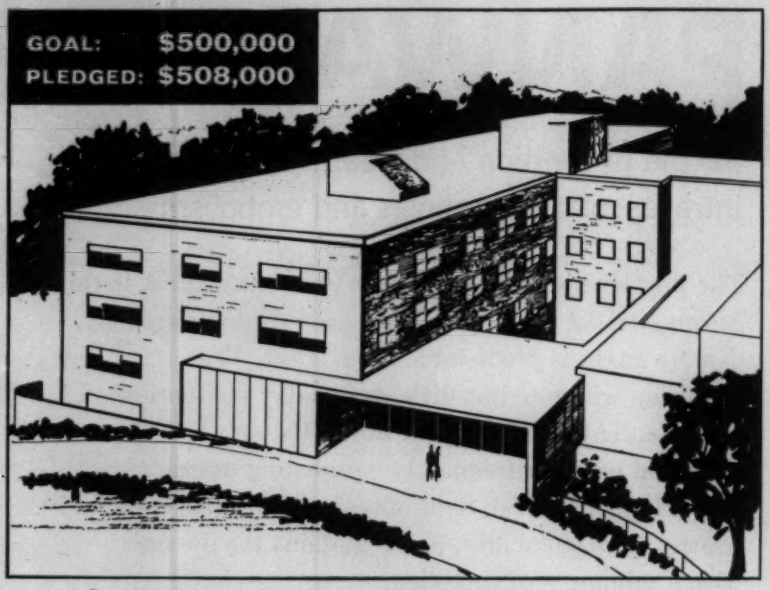
● **Kent Griffin** (see Robert Trimble item).

● **Arden E. Hardgrove** has retired from active service at Norton Memorial Infirmary, Louisville, Ky. He had been acting as administrative consultant to the institution since his resignation as administrator in March 1958. He had been administrator at Norton Memorial Infirmary for 20 years. During his career, Mr. Hardgrove served as president, secretary and treasurer of the Kentucky and Ohio state hospital associations, and for six years as member of the board of regents of the American College of Hospital Administrators.

● **Erland D. Kiddie** has been appointed administrative assistant of Penrose Hospital, Colorado Springs, Colo. Before his retirement from the U.S. Army, Major Kiddie was chief medical statistician, Ft. Carson (Colo.) U.S. Army Hospital, and earlier executive officer at U.S. Army Hospital, Camp Irwin, Calif. He also held other medical administrative positions during his army service. Major Kiddie has a B.A. degree

MAJ. KIDDIE

(Continued on page 166)



Drawing of proposed addition to Nyack Hospital, Nyack, New York

WITH KETCHUM, INC. CAMPAIGN DIRECTION,

Nyack Hospital raises funds for expansion to keep pace with population boom

Population is growing rapidly in the eastern Rockland County area served by Nyack Hospital, Nyack, N.Y. Even now, the hospital's facilities are strained beyond normal capacity. To meet the population boom head-on, the Hospital Board decided to act without delay. Ketchum, Inc. was called in to direct a $500,000 building-fund campaign. The community responded with total pledges of $508,000.

At the end of the campaign, Russell M. Drumm, Administrator, said this about Ketchum, Inc. service. "I believe our success was due largely to your thorough development of plans and effective direction of the campaign."

If your hospital is planning a fund-raising campaign, we will be happy to discuss your plans with you at no obligation.

MEMBER AAFRC

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JOHNSTON BUILDING, CHARLOTTE 2, N.C.

every 7½ seconds another life begins

. . . and 8% are premature

4,350,000* babies will be born in the United States this year—and 8% will be premature. These premature infants should be given every chance for survival. Does your nursery have enough ISOLETTE® incubators?

The ISOLETTE incubator alone provides precise, continuous, fully-automatic control of temperature, humidity and oxygen—vital factors of the premature infant's environment.

When nursery air is used, only the ISOLETTE incubator insures maximal isolation by means of the new ISOLETTE MICRO-FILTER. It removes all contaminants down to 0.5 micron in size. And if the exclusive outside connection is used, the ISOLETTE incubator provides a continuous supply of circulating, pathogen-free, fresh, outside air.

To be ready for the increasing number of premature births—and for optimal protection of even the tiniest infant—make sure your nursery has enough ISOLETTE incubators.

*4,320,000 births were recorded by U.S. Dept. of Comm. in 1959.

The Isolette®

infant incubator by **AIR-SHIELDS, INC.**

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"Rainbow"

THE WET PICK-UP MACHINE

The new Rexair is the *only* cleaner that drowns dirt and dust in a water bath! This, and its patented whirling separator, makes the Rexair Rainbow different from all cleaners in design, function, results. You can see dirt collected in Rexair's clear plastic basin. With its water principle, constant suction is maintained—only fresh, purified air is exhausted into the room. Write for descriptive literature.

THE ONLY CLEANER THAT ELIMINATES ALL . . .

Filters . . . Throw-away Bags . . . Cloth Bags

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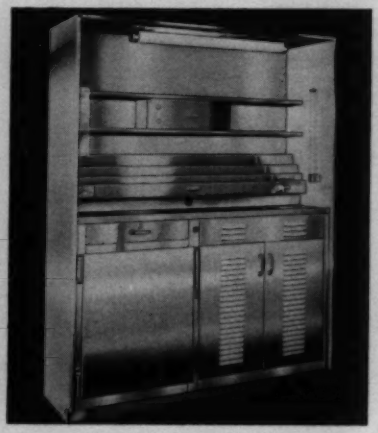
equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

Medicine station (6E-1)

Manufacturer's description: This 60-in. wide unit for nurses' stations combines in a sanitary, stainless steel cabinet, a 4-cubic-foot refrigerator, a sink with pushbutton water

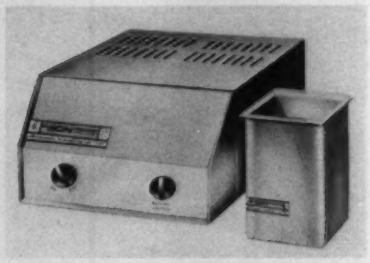


faucet, tiered storage shelves, a safety-lock narcotics cabinet and other labor-saving and safety features for the storage, preparation and dispensing of medications. It is also available with tempered plate glass doors equipped with locks for use in exposed locations.

Market Forge Co., Hospital Division, Dept. H5, Everett, Mass.

Ultrasonic cleaner (6E-2)

Manufacturer's description: The ultrasonic cleaner is low in price and compares in power, cleaning tank capacity, performance and appearance with those of higher price. It



If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

- _____ Medicine station (6E-1)
- _____ Ultrasonic cleaner (6E-2)
- _____ Electronic air cleaners (6E-3)
- _____ Dish cart (6E-4)
- _____ Mobile food service unit (6E-5)
- _____ Closed circuit television (6E-6)
- _____ Bedside pedicure unit (6E-7)
- _____ Baby crib (6E-8)
- _____ Charting desk (6E-9)
- _____ Coffee urn (6E-10)
- _____ Trapeze bar (6E-11)
- _____ Laboratory equipment (6E-12)
- _____ Copying machine (6E-13)
- _____ Lounge cot (6E-14)

PRODUCT LITERATURE

- _____ Safety (6EL-1)
- _____ Air diffusion equipment (6EL-2)
- _____ Hospital casters (6EL-3)
- _____ Metal windows (6EL-4)
- _____ Laboratory ware (6EL-5)
- _____ Microtome (6EL-6)
- _____ Mattresses (6EL-7)
- _____ Laundry equipment (6EL-8)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

(Please type or print in pencil)

SAFEGUARD IDENTIFICATION BANDS
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Ladies and gentlemen
I have been asked to announce
That in the month of February over 1,000,000 (one million)
SAFEGUARD identification bands were used in hospitals in the U.S.A. and Canada
It's the finest identification band made and at HALF THE COST of most other leading I.D. products
Don't place another order until you've seen the NEW SAFEGUARD now made with "SUPER-STRENGTH" polyethylene
We'll be very delighted to send you samples
We thank you

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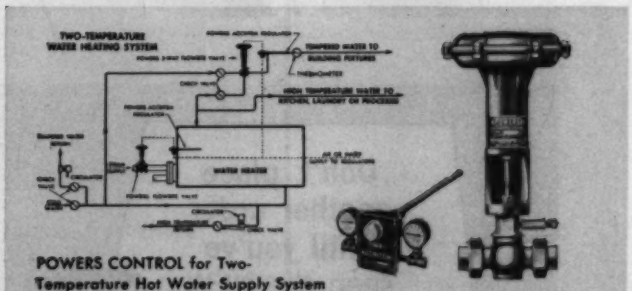
In Colorado's largest private general hospital

ST. MARY-CORWIN HOSPITAL
PUEBLO, COLORADO
Architects: MONROE, IRWIN & DUNHAM, Denver, Colo.
Mechanical Engineers: MARSHALL & JOHNSON
Mechanical Contractor: NATKIN & COMPANY
General Contractor: ROBERT E. McKEE

For more than 75 years the Sisters of Charity have been caring for the sick in Pueblo's St. Mary Hospital. Now its new imposing structure the St. Mary-Corwin Hospital contains modern facilities unsurpassed for diagnosis and treatment of disease, patient care and comfort. Powers Temperature Control here helps increase hospital efficiency.

Above: Recovery room for efficient post operative care



POWERS CONTROL for Two-Temperature Hot Water Supply System here prevents wasted fuel and danger of overheated water.

(D8)

THERMAL COMFORT throughout is provided by POWERS Temperature Control for each individual room and various types of baths

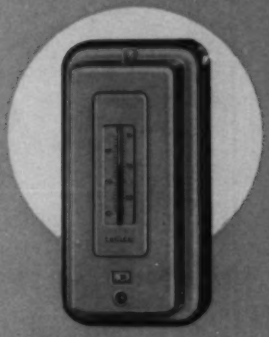
Proper Thermal Environment is important in this 450 bed hospital. Patients, nurses, doctors and staff benefit from Powers air conditioning control in the surgical suite consisting of 8 major and 3 minor operating rooms, recovery and delivery rooms, X-Ray department, laboratory, maternity department and pediatric unit. Temperature in other spaces is also regulated by Powers individual room control system.

Greater Simplicity and year after year dependability of a Powers Pneumatic Control-System provides these money saving benefits —

Lower Heating Costs — Powers accurate control prevents discomfort of over-heating and reduces fuel losses.

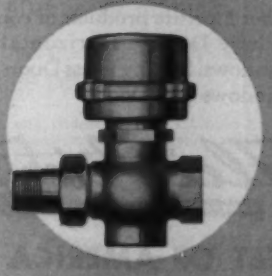
Lower Maintenance Cost — 25 to 40 years of dependable control with a minimum of repairs is often reported by users of pneumatic control systems. Some are still in operation after 50 years of service.

Powers Complete Responsibility — for a correctly engineered control system, proper installation, continuous successful operation and prompt SERVICE, when required, from offices in 85 cities.



732 Powers Pneumatic Thermostats maintain set temperatures constantly. They need no daily checking or readjusting. Patients, nurses, doctors, staff and visitors all benefit from the THERMAL COMFORT they provide throughout the hospital.

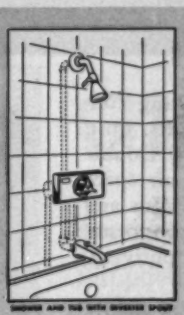
NO MORE Valve Packing Maintenance or Water Leakage with Powers PACKLESS Valves.



864 Powers PACKLESS Control Valves are used here on convectors, and unit ventilators. They're labor savers, and cut the cost of maintenance.

For Sitz Baths, Shampoo Tables, Arm and Leg Baths, etc.

PATIENT'S SAFETY and COMFORT in Hydrotherapy, showers, and infant baths are assured by Powers HYDROGUARD thermostatic water mixers. They are also used for X-Ray film developing, surgeon's wash-up sinks, artificial kidneys, blood coolers in heart surgery and many other applications.



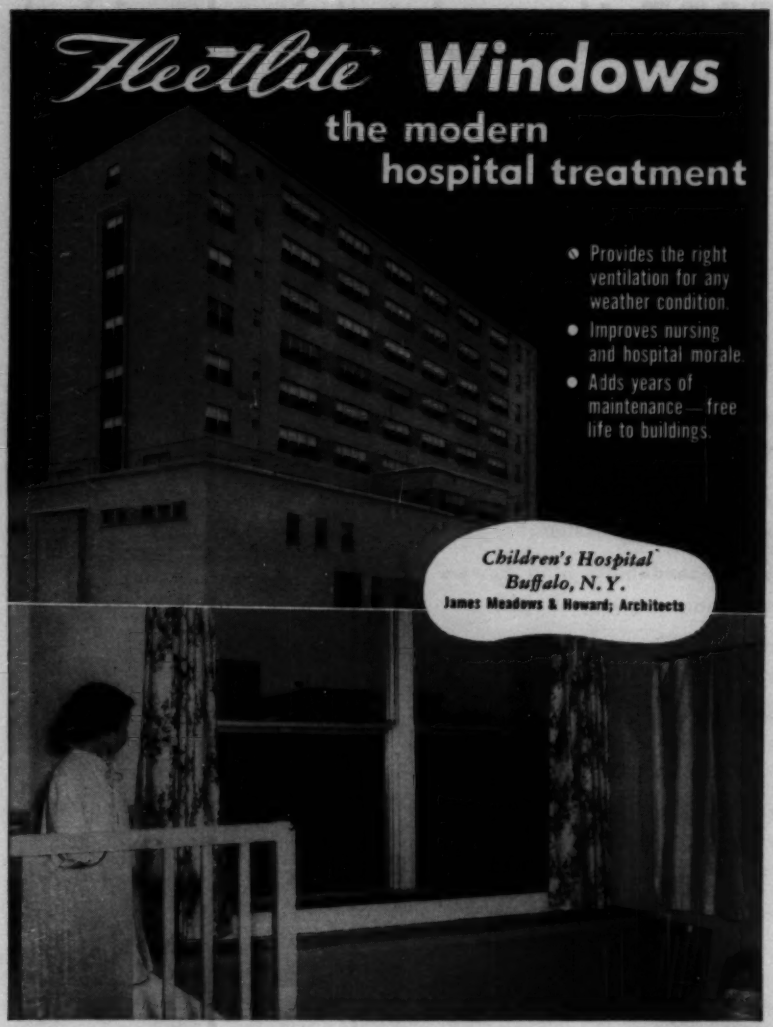
Powers makes the most complete line of water temperature control

Are You Planning a New Hospital? No other single firm makes so many of the essential thermal comfort controls for modern hospitals as POWERS. Only a few are shown above. Ask your architect or engineer to include a Powers Quality System of Thermal Comfort Control—throughout the building for heating, air conditioning, various baths and hot water heaters.

THE POWERS REGULATOR COMPANY

SKOKIE, ILL. | *Offices in 85 Cities in U.S.A. and Canada*

MANUFACTURERS OF THERMOSTATIC CONTROLS SINCE 1891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the modern
hospital treatment
• Provides the right ventilation for any weather condition.
• Improves nursing and hospital morale.
• Adds years of maintenance—free life to buildings.
Children's Hospital
Buffalo, N.Y.
James Meadows & Howard; Architects

The tight weatherstripped and interlocking construction of Fleetlite windows stops drafts, dust, noise, rain and snow for extra comfort. Double window design provides the insulating air space that saves heating and air conditioning costs and permits indirect ventilation during rainstorms. Fleetlite windows never need painting or puttying. Save maintenance costs.

Other Fleetlite products of comparable high quality include Double Horizontal Sliding Windows, Sliding Glass Doors, Jalousie Windows and Doors.

All sash easily removable from the inside for cleaning.

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AMERICA'S finest WINDOW ®

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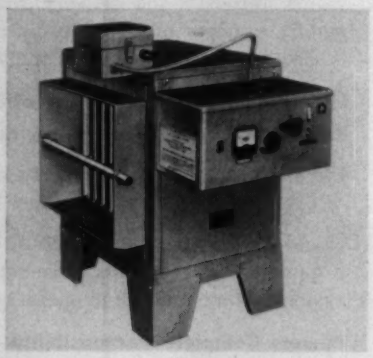
will disintegrate more than 50 distinct classes of soils and contaminants in seconds, removing them from surgical instruments. It includes a powerful 40-watt generator with an output of 90,000 cycles per second, the ideal frequency for small parts cleaning. *Ultrasonic Industries Inc., Dept. H6, 141 Albertson Ave., Albertson, L.I., N.Y.*

Electronic air cleaners (6E-3)

Manufacturer's description: Electronic air cleaners, useful for smaller hospitals, were made possible by reducing ionizing-collecting cell plate spacing to 5/16 in. and by the application of other refinements in



cell and power pack design. The resulting units require less space and produce both horizontal and vertical air flow. *Electro-air Cleaner Co., Inc., Dept. Z, Dept. H6, Olivia and Sproul St., McKees Rocks, Pa.*

Dish cart (6E-4)

Manufacturer's description: The double-decker dish cart is made of highly polished, chrome-plated steel alloy tubing. It features containers which can be removed easily, but which cannot fall or slide off the rack. They are double the size of the ordinary dish containers. Four-inch

Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

Glarubin*

TABLETS

specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

Write for descriptive literature, bibliography, and dosage schedules.

1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

*U.S. Pat. No. 2,864,745

THE S.E. MASSENGILL COMPANY

BRISTOL, TENNESSEE

NEW YORK • KANSAS CITY • SAN FRANCISCO

the Bed of Many Uses

Hill-Rom No. 43 Recovery Bed meets many special needs in...

- **Intensive Care Unit**
- **Post Operative Recovery Room**
- **Labor Room—Emergency Delivery Room**
- **Post-Partum Recovery Room**
- **Eye Clinic or Department for "EYE" Patients**
- **Cast Room in Orthopedic Department**
- **Out-Patient or Emergency Room**

Although designed to meet special needs, Hill-Rom No. 43 Recovery Bed is as comfortable as the hospital bed used in the patient room or unit. It is equipped with an adjustable Trendelenburg spring, insuring quick adjustment to shock or any other desired position when needed; also an innerspring mattress. A mattress guard at the foot end of the spring holds the mattress securely in place.

Head and foot ends of aluminum or wood may be removed for easy access to the patient in giving treatment or nursing care. Full length side-guards are permanently mounted on the bed, and can be raised and lowered without difficulty. Conductive rubber casters make the bed very easy to move around—and ideal for use in transferring patients to and from surgery, clinics, X-Ray department, etc. Wrap-around bumpers protect the walls and doors.

The IV Rod is permanently stored under the foot end of the bed and can be quickly and conveniently placed in any of the six locations on the bed.

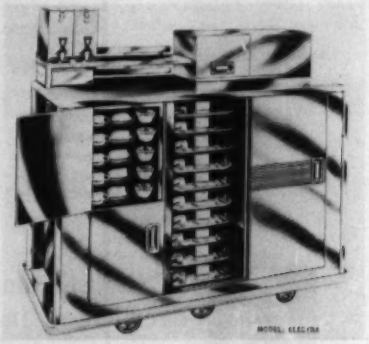
Instruction Manual No. 2—"For Beds that answer Special Needs" by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom, gives complete information on the care and use of this and other special purpose beds. Sent on request.

HILL-ROM COMPANY, INC. • Batesville, Indiana

swivel caster wheels make the cart fully and easily maneuverable and aid in the quiet movement of the car and containers. *McClintock Mfg. Co., Dept. H6, 802 W. Whittier Blvd., Whittier, Calif.*

Mobile food service unit (6E-5)

Manufacturer's description: The mobile food service unit features a match-a-tray method. With this tray loading method, diet maids have little difficulty in matching the hot tray items to the cold items on the patient's tray. Other outstanding



features are an ice cream and cold nutrient section; removable beverage containers that may be fully immersed and run through all dishwashing systems; convenience outlet; increased vertical clearance between trays in the cold compartment, and added work space. *Crimsco, Inc., Dept. H6, 5001 E. 59th St., Kansas City 30.*

Closed circuit television (6E-6)

Manufacturer's description: The closed circuit television camera is available in different versions, providing either locked or random interlace, and either automatic or manual light compensation. The camera uses a standard 16 mm C

(Advertisement)

Take a Close Look at Hospital Injectables

Reading time: 2½ minutes **Benefits: 12**

There is little doubt that disposable equipment has assumed great importance in the modern hospital. Certainly, no hospital administrator would dispute the fact that disposable items such as knife blades, blood lancets, urine collection bags, catheters, and enemas all help increase efficiency and, often, cut costs.

On the other hand, much can be said for equipment of a more permanent nature. Personnel have usually had experience with it. There's no need for constant re-ordering; the cupboard is rarely bare.

You can have both

The advantages of disposable and permanent equipment do not necessarily have to be separate and distinct. In the TUBEX® closed-system of injectables, for example, the best features and advantages of both are combined. The system comprises a durable, finely made syringe and a disposable cartridge (glass) and needle unit containing a pre-measured dose of medication.

Injection with TUBEX *simply requires that the proper pre-filled cartridge-needle unit be selected, inserted in the syringe, and aspirated. After the injection has been given, the cartridge-needle unit is discarded; the syringe is ready to use again . . . and again . . . and again . . .*

The benefits that the TUBEX system brings to hospital personnel, and the contributions that it makes to hospital efficiency and the welfare of patients, are impressive. Consider, if you will, the following examples.

1. Accurately measured dose assured
2. Danger of giving wrong drug reduced

Each sterile cartridge-needle unit contains an accurate, clearly labeled dose. Therefore, the nurse no longer must measure out doses as before—perhaps from an often-used, possibly contaminated multiple-dose vial. She runs little risk of administering an inaccurate dose or, worse yet, the wrong drug entirely. Obviously, the less chance for error the fewer the number of malpractice suits.

3. Efficiency of Central Supply increased
4. Breakage losses reduced

TUBEX cartridge-needle units are pre-sterilized; the needles pre-sharpened. This means that Central Supply can turn its attention to duties other than the time-consuming sterilization of syringes and the sharpening and sterilization of needles. It also means that breakage, which invariably accompanies these operations, and which raises the hospital's costs, is drastically reduced.

5. A source of hepatitis eliminated
6. Contact sensitization minimized

TUBEX cartridge-needle units serve for a single injection only. There can be no contaminated needles to transmit serum hepatitis or other diseases. Also, because there is virtually no chance for spillage, the nurse rarely comes into contact with drugs that might produce dermatitides or be absorbed to cause even more serious effects.

7. Inventory control simplified
8. Narcotic security tightened

The TUBEX system requires only two parts, half as many as the "conventional" system.

TUBEX System: cartridge-needle unit, syringe
Conventional System: plunger, barrel, needle, medication

There are fewer records to keep. Inventory control, therefore, is more accurate and efficient. As inventory control becomes more accurate, narcotic security automatically tightens.

9. Patients react more pleasantly to injections
10. Most commonly used drugs available

The most obvious direct benefit that the TUBEX system provides for the patient is a relatively painless injection, the result of a fresh, pre-sharpened, single-use needle. Since most common drugs—and many uncommon ones as well—are available in TUBEX form, the majority of hospital patients can benefit from the TUBEX system.

11. Accounting made more efficient
12. Billing made more accurate

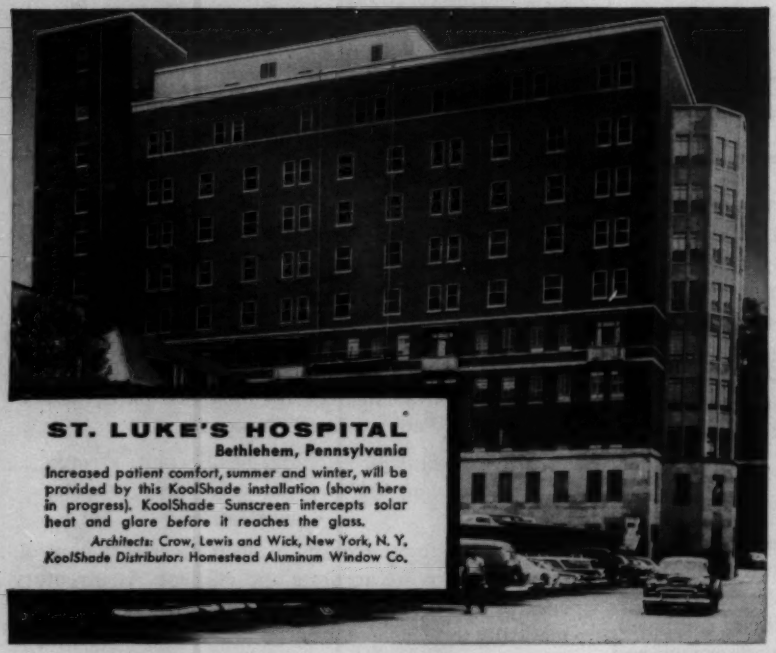
Since each cartridge-needle unit contains a single, pre-measured dose, the amount of medication, including narcotics, that is given a patient is readily ascertainable. Hence, accounting is facilitated and the proper charges to the patient can be made accurately and easily.

In summary

As you can see, adoption of the TUBEX system can have far-reaching effects. Efficiency and morale of the staff are improved. Labor costs—currently about 70 cents of every dollar spent by the hospital—are markedly reduced. Accounting, billing, and inventory control are made more accurate. The risk of malpractice suits is mitigated. The well-being of patients is enhanced.

The TUBEX system can presently supply more than 75 per cent of injectables commonly administered in hospitals. And medications not yet available in TUBEX form can be administered by means of empty, sterile cartridge-needle units. Thus, the TUBEX system is capable of meeting every need for injectables.

The TUBEX system is already in wide use. To learn more about the many benefits that the TUBEX system can bring to *your* hospital, please see your Wyeth Territory Manager or write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.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KoolShade Distributor: Homestead Aluminum Window Co.

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③ **Reduces solar glare.** Widely used as a daylighting aid, KoolShade moderates sun and sky glare. Screens out direct solar rays to improve lighting balance, guards against eye-strain.

④ **Gives full outward visibility.** Because it's woven (not stamped), KoolShade permits up to 83% clear outward visibility...greater view by far than *any* comparable shading device.

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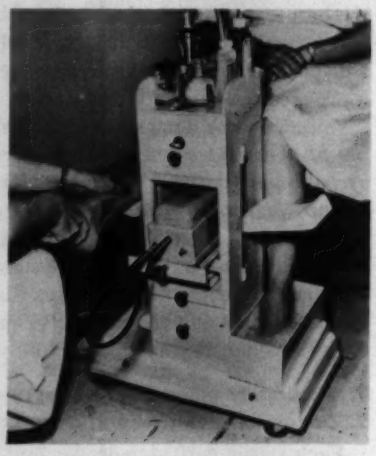
lens mount and can accommodate a remote control four lens turret. Such remotely controlled functions as pan and tilt, iris control, focus and zoom lens can also be added to the camera. The rugged 14-inch monitor provides virtually perfect interlace fields when used with the locked interlace camera. *Motorola Inc., Communication and Industrial Electronics Div., Dept. H6, 4501 W. Augusta Blvd., Chicago 51.*

Bedside predicure unit (6E-7)

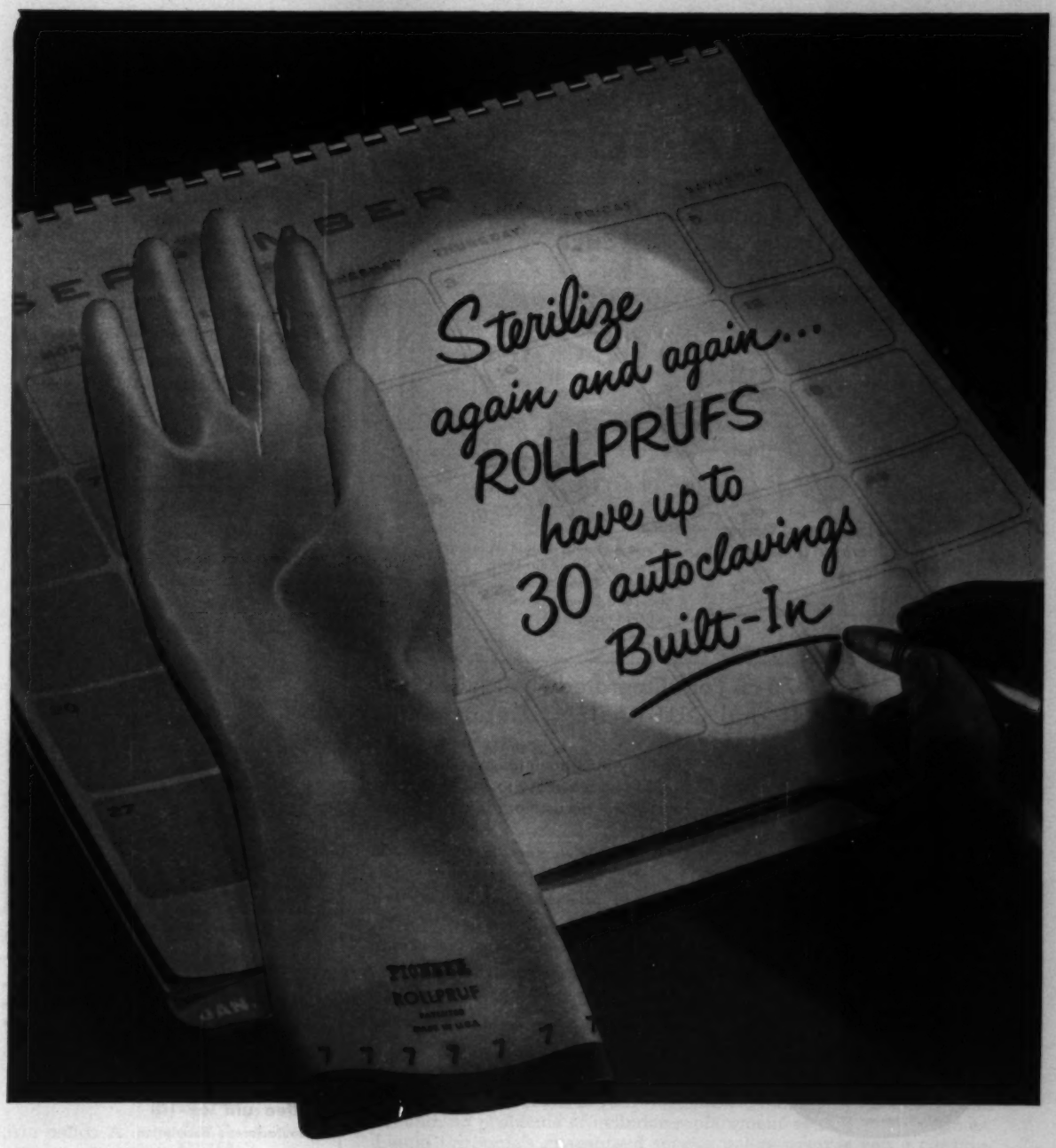
Manufacturer's description: Bedside pedicures for ambulatory and bedridden patients in sitting or prone positions can be given easily with this mobile unit. The unit includes an ultra-violet sterilized compartment, key-locked for safety and convenience; electric foot massage; an individual sanitary foot bath



which adjusts to right and left foot positions; sanitary leg rests raised to bed or chair height; a rugged chrome slide bar that locks in position; clean towel storage; a slide-out shelf for mechanical pedicure and manicure, and attached adjustable worklight. The unit moves quickly and effortlessly through narrow corridors and raised doorways on easy-gliding ball-bearing rollers. *Falcon Mfg. Co., Inc., Dept. H6, 148 Fordyce, Dallas.*

Baby crib (6E-8)

Manufacturer's description: The baby crib has sides of sturdy nylon netting instead of rigid slats. It also has upholstered vinyl headboards and a strong tubular steel frame. The sides fold down, doing away with any need to raise or lower the mattress. It also eliminates awk-



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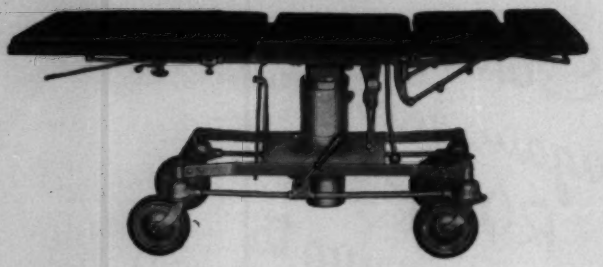

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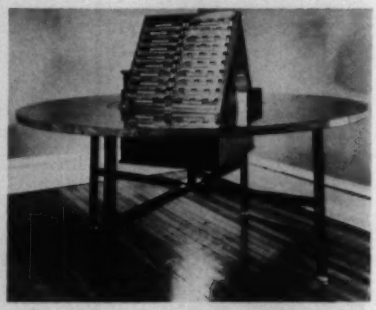
Dept. H-316, 96 Caldwell Drive, Cincinnati 16, Ohio

ward bending to lift the child out of the crib. There are no unyielding openings in the netting where arms and legs might get caught and held. *Hamilton Cosco, Inc., Dept. H6, Columbus, Ind.*

Charting desk (6E-9)

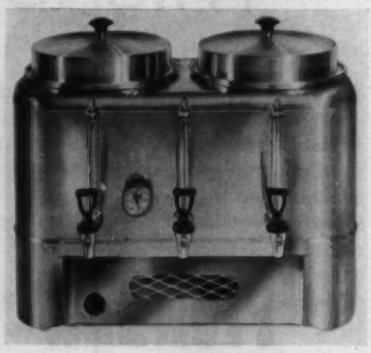
Manufacturer's description: The charting desk for hospital wards has been developed to simplify the process of chart recording and reading by doctors, nurses and technicians, by locating at a central point, the charts of all patients in one nurs-



ing area. Charts are stored in a vertical chart holder which revolves in the center of the desk. Patients' names are readily visible. *National Cylinder Gas Div. of Chemetron Corp., Dept. H6, 840 N. Michigan Ave., Chicago 11.*

Coffee urn (6E-10)

Manufacturer's description: A coffee urn, with a working height of only 19½ in., solves space problems and is



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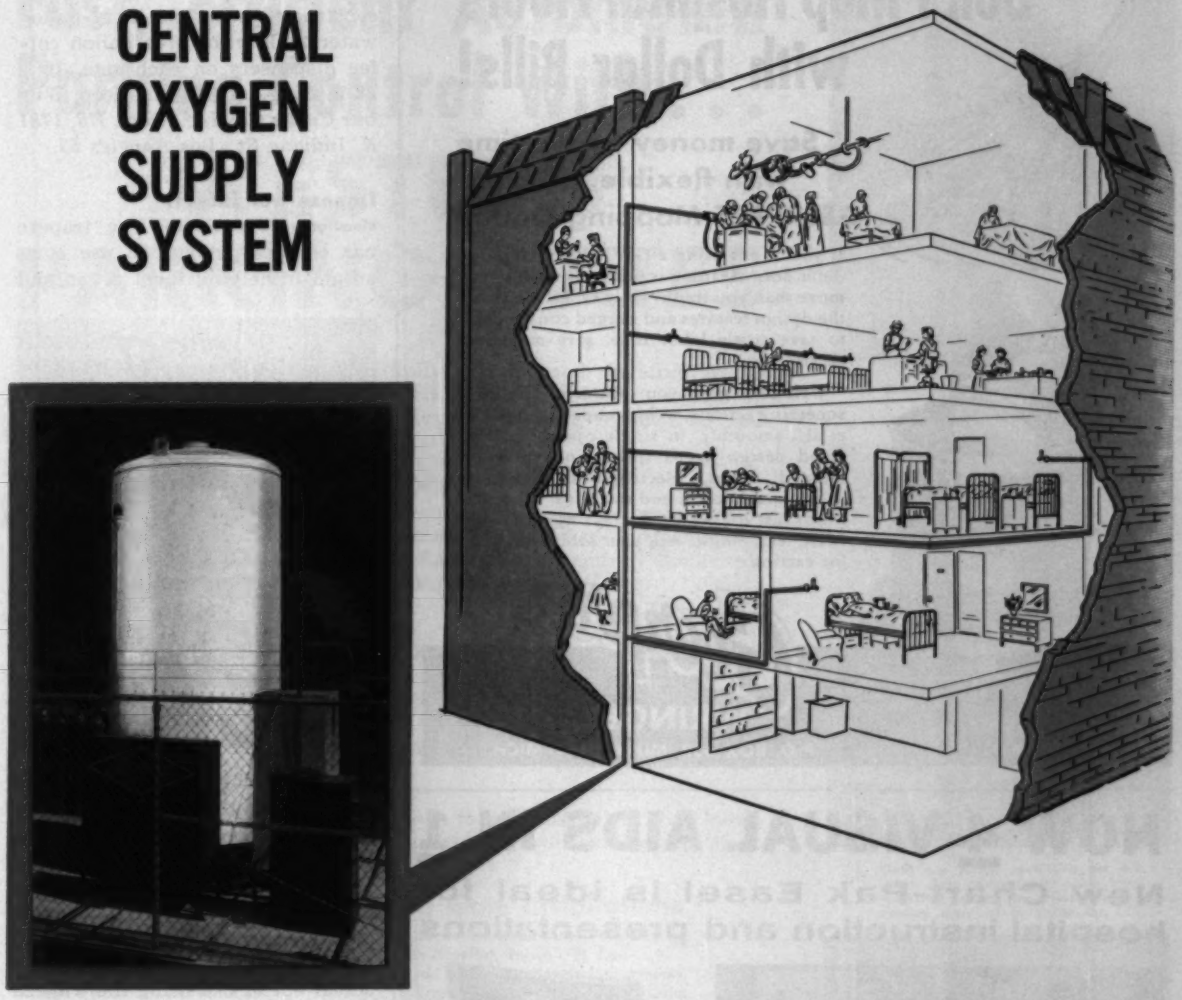

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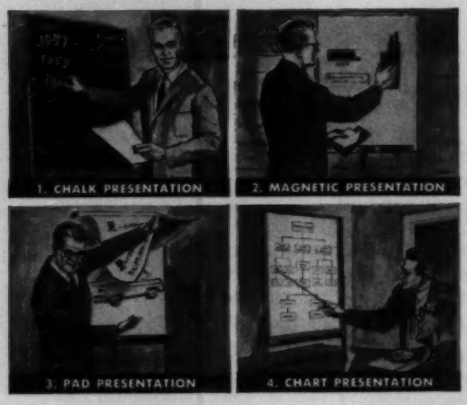

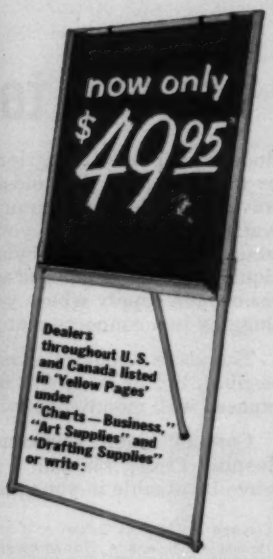
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designed for easier brewing and cleaning. This all stainless steel-constructed urn has a 12-gallon water tank with three-gallon coffee dispensers on each side. It is 28 in. long and 17½ in. deep. *Wilbur Curtis Co., Inc., Dept. H6, 1781 N. Indiana St., Los Angeles 63.*

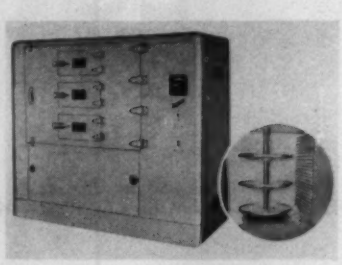
Trapeze bar (6E-11)

Manufacturer's description: The trapeze bar enables patients to use it as an aid in helping them get in and

out of bed. The bar hangs on a link chain, permitting height adjustment. The locking arrangement locks it firmly in any position. When directly over the patient, it can be used to adjust weight or as an exercise bar. Pivoted 45 degrees, patients can easily swing themselves out of bed using the trapeze bar to support their full weight. When not in use, it can be swung completely out of the patient's way. Stops prevent it from hitting walls. *Simmons Co., Dept. H6, Merchandise Mart Plaza, Chicago 54.*

Laboratory equipment (6E-12)

Manufacturer's description: The rotary shelf laboratory oven features precision control of uniform heat. The rotary shelves, operated either manually or mechanically, are



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Methodist Hospital, Indianapolis, Ind.
Iowa Methodist Hospital, Des Moines, Ia.
Bethany Hospital, Kansas City, Kan.
Mercy Hospital, New Orleans, La.
Holy Cross Hospital, Detroit, Mich.
St. Luke's Hospital, Duluth, Minn.
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Lutheran Hospital, Omaha, Nebr.
Children's Hospital of Buffalo, Buffalo, N. Y.
Lebanon Hospital, New York City, N. Y.
Rex Hospital, Raleigh, N. Car.
Good Samaritan Hospital, Cincinnati, O.
Hillcrest Medical Center, Tulsa, Okla.
Albert Einstein Medical Center, Philadelphia, Penn.
Newport Hospital, Newport, R. I.
Medical College Hospital, Charleston, So. Car.
East Tennessee Baptist Hospital, Knoxville, Tenn.
St. Paul's Hospital, Dallas, Texas
Holy Cross Hospital, Salt Lake City, Utah
Mountain State Hospital, Charleston, W. Va.
Milwaukee Children's Hospital, Milwaukee, Wis.

Photos: Louisiana State University Medical School, New Orleans, right; Bishop Clarkson Memorial Hospital, Omaha, Nebr., left.

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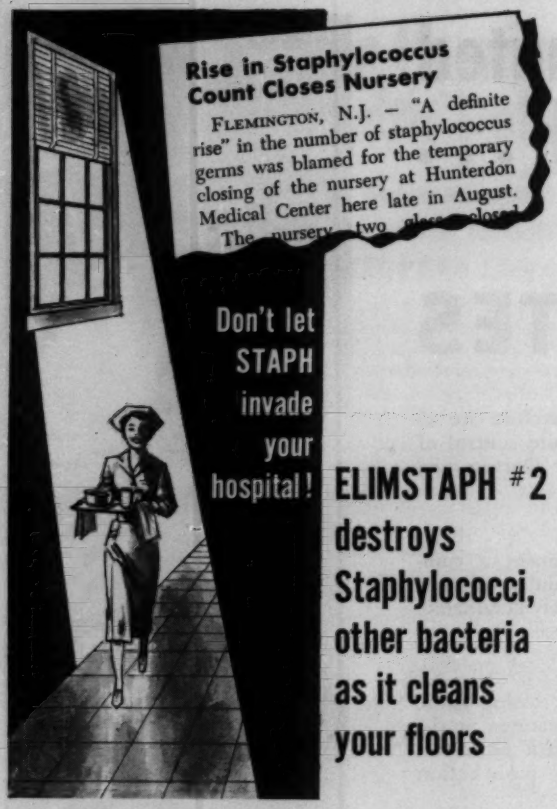
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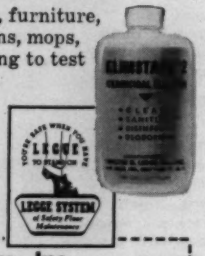

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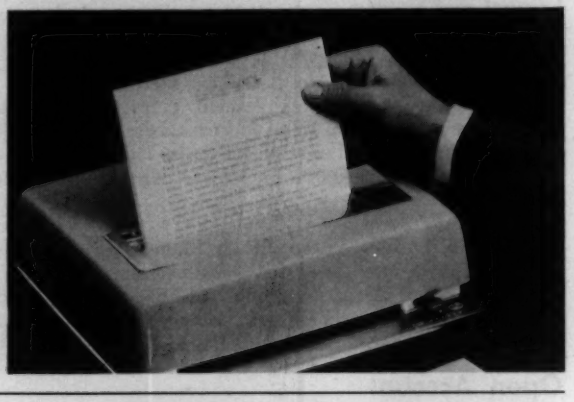
spaced on 12-inch vertical centers. Maximum oven temperature is 850°F. A motor and reduction gear maintain constant shelf rotation at higher temperatures. Other features include hinged plug-type doors located within one main door on the same level as the rotary shelf for easy product removal. Each door is provided with a heat resistant glass window. *Despatch Oven Co., Dept. H6, 619-8th St. S.E., Minneapolis 14.*

Copying machine (6E-13)

Manufacturer's description: This is a compact, lightweight copying machine styled for desk-top use and operating on the completely dry, all-electric copying principle. The unit weighs only 25 pounds and is operated by a single control. It measures 14½ in. wide, 12½ in. deep and 4½ in. high. The machine is designed to



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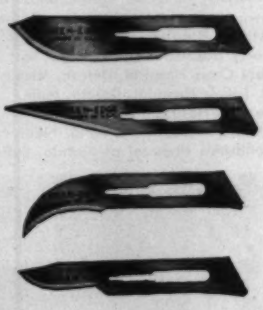

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accommodate a bond-weight white copy paper. Since no chemicals or liquids are involved, the unit is merely plugged in and turned on. Copies are made in eight seconds or less. *Minnesota Mining and Mfg. Co., Dept. S9-515, Dept. H6, 900 Bush Avenue, St. Paul 6.*

Lounge cot (6E-14)

Manufacturer's description: The lounge cot's rugged hydraulic unit raises or lowers the largest patient with ease.

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(Continued on page 134)

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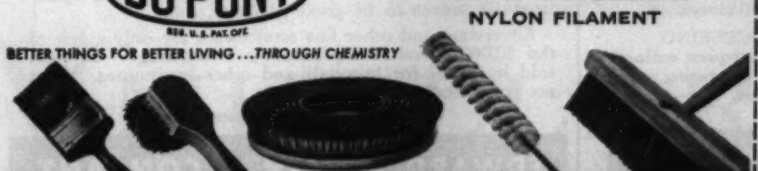

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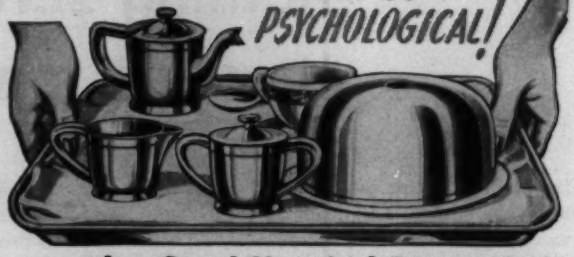

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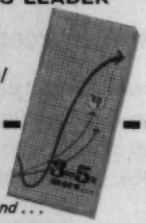

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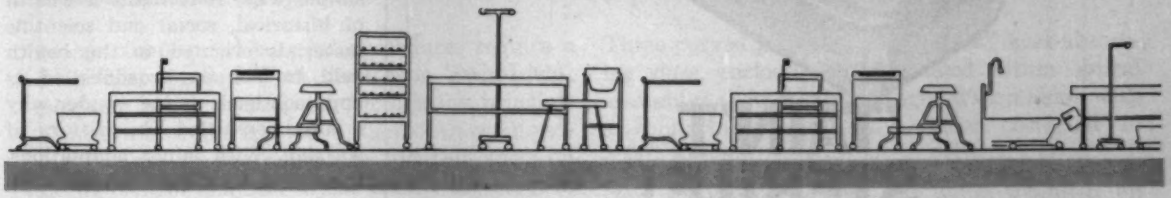

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THE HISTORY OF NURSING; AN INTERPRETATION OF THE SOCIAL AND MEDICAL FACTORS INVOLVED. Richard Harrison Shryock. Philadelphia, Saunders, 1959. 330 pp. $5.

In reading the table of contents of this book, the headings of the 14 chapters sound similar to those of most histories of nursing covering primitive times to modern American nursing. Actually, however, it differs rather markedly, for relatively little space is used in discussing nursing except in the last two chapters. The author states that his purpose is not simply to retell the story of nursing but rather "to present that story in close relationship to its scientific as well as social background". In fact, a considerable portion of the book is descriptive of medical practice, medical institutions and the medical profession.

Although the author states that the reader could read at random, this reviewer followed his advice and read the entire book from beginning to end "in order to attain a vista of the long sweep of nursing through the centuries" and did so without stopping. It is an eminently readable and interesting book written in a deceptively simple way. It contains a wealth of historical, social and scientific materials oriented to the health field. In fact, the broadness of its approach leads one to wonder why it has been titled *The History of Nursing*. With minor adaptations, this could well have been a book on the social and scientific factors involved in the development of the health field and addressed not only to health personnel but to the public at large.

The next to last chapter discusses the beginnings of modern nursing and various attempts to train nurses. The last chapter, a total of 24 pages, describes American nursing after 1870. The sweeping way in which the development and financing of nursing education, nursing leaders, licensure, military nursing, nursing organizations and professional status are treated, and the selectivity that this has necessitated, has led to some misleading statements. However, a sympathetic understanding of problems and potentials in nursing is evident.

The author states in the preface that the long sweep "may offer to

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those who wish to pursue it some of the values of liberal education". The extremely broad approach, moving rapidly, creates a desire to turn back to more extensive historical reading. One is impressed by the extent of the source materials and readings that must have gone into the preparation of the manuscript, and regrets that these are not shared with the reader in the form of a bibliography. There are relatively few footnotes (51 in the entire book) about half of which are source references. This lack adds to the readability of the book without the customary distraction of footnotes, but one's curiosity is often aroused as to the source of many statements.

This is a book that could be read with interest and profit, not only by nurses, but also doctors, hospital personnel, those connected with health agencies or anyone having an interest in the health field. It creates a sense that the present takes on "new significance when fitted into its place in a long and unfinished epic". The serious student of nursing would need to turn to more definite histories of nursing for details about nursing and nursing education.—BERNICE E. ANDERSON, ED.D., *professor of nursing education, Teachers College, Columbia University.*

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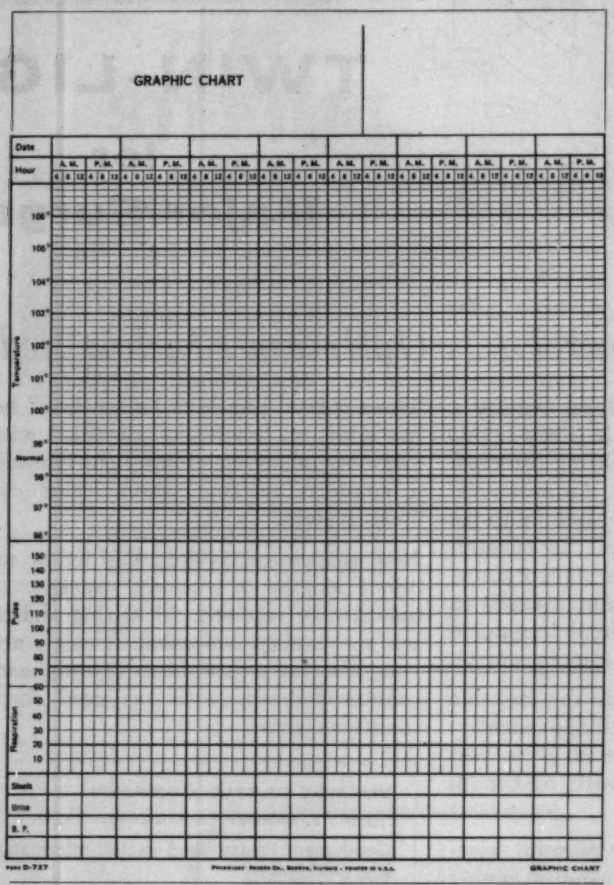

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WORKSHOP-CONFERENCE ON THE ROLE OF THE DIRECTOR OF MEDICAL EDUCATION IN THE HOSPITAL; conducted by the American Hospital Association; cosponsored by the American Medical Association and Association of Hospital Directors of Medical Education; in cooperation with the Association of American Medical Colleges; through a grant from the Wyeth Fund for Postgraduate Medical Education, Palmer House, Chicago, January 16-17, 1959. Chicago, American Hospital Association, 1959. 36 pp. Free.

The number of directors of medical education in our hospitals has been increasing rapidly in the past five years without the benefit of a definite statement concerning the real responsibilities and status of these physicians. Because of this, the American Hospital Association felt it necessary to initiate a study of this new facet of the hospital's role in education.

The workshop conference consisted of two days of discussion in which 36 individuals from all areas of this field participated. Matters discussed included the need and purpose of the director of medical education, his relationship with the medical staff and governing board, his necessary qualifications, the question of clinical care of patients by the director of medical education, his role as a representative of the medical staff and the administrative staff, and the types of hospitals which would receive the most benefit from the services of a director of medical education. In addition, there was considerable discussion concerning the role of the director of medical education in the training of the paramedical groups.

It is the plan of the American Hospital Association to continue, in cooperation with other interested organizations, to set up programs in this same area.—J. R. ANDERSON, M.D.

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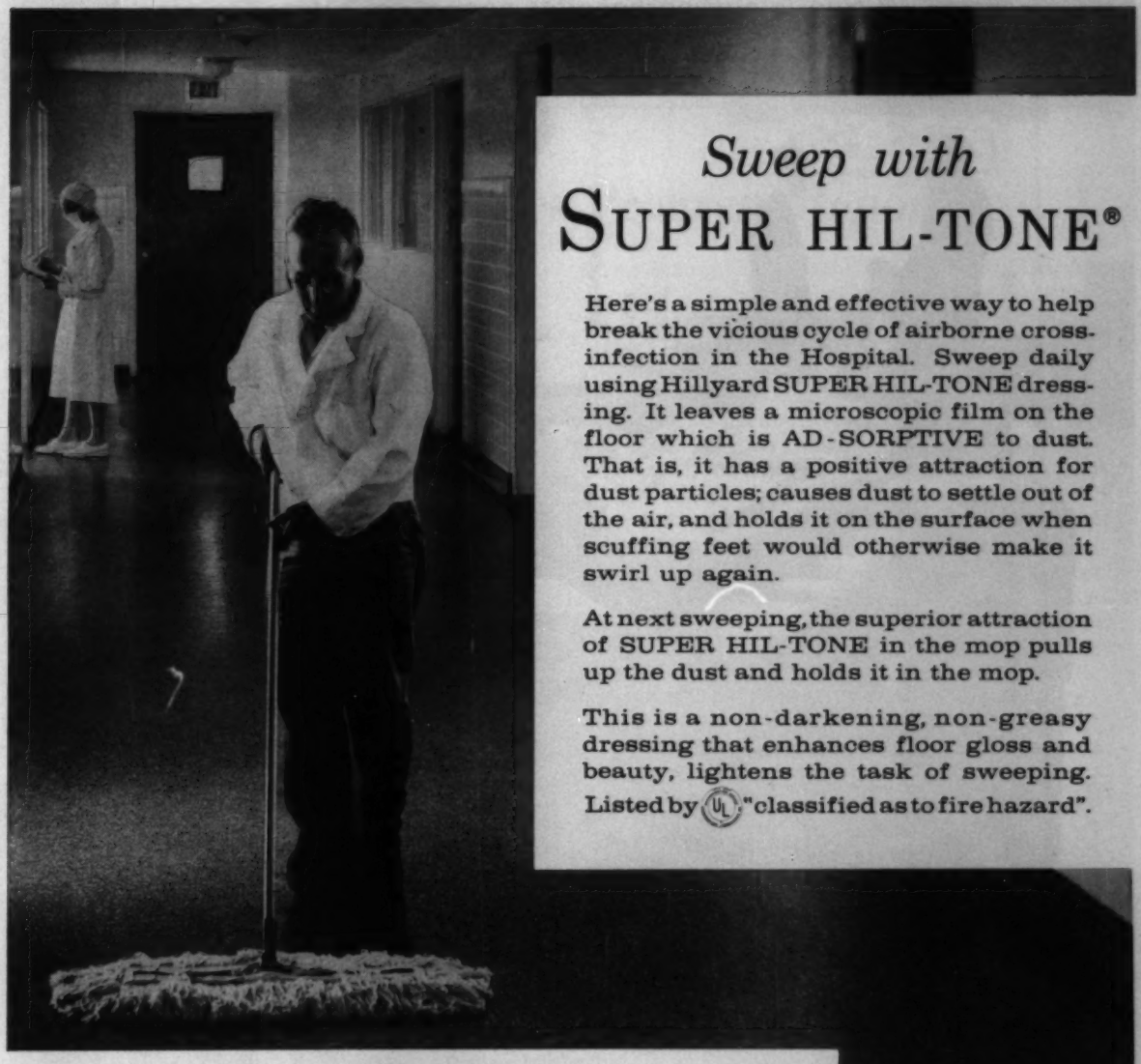

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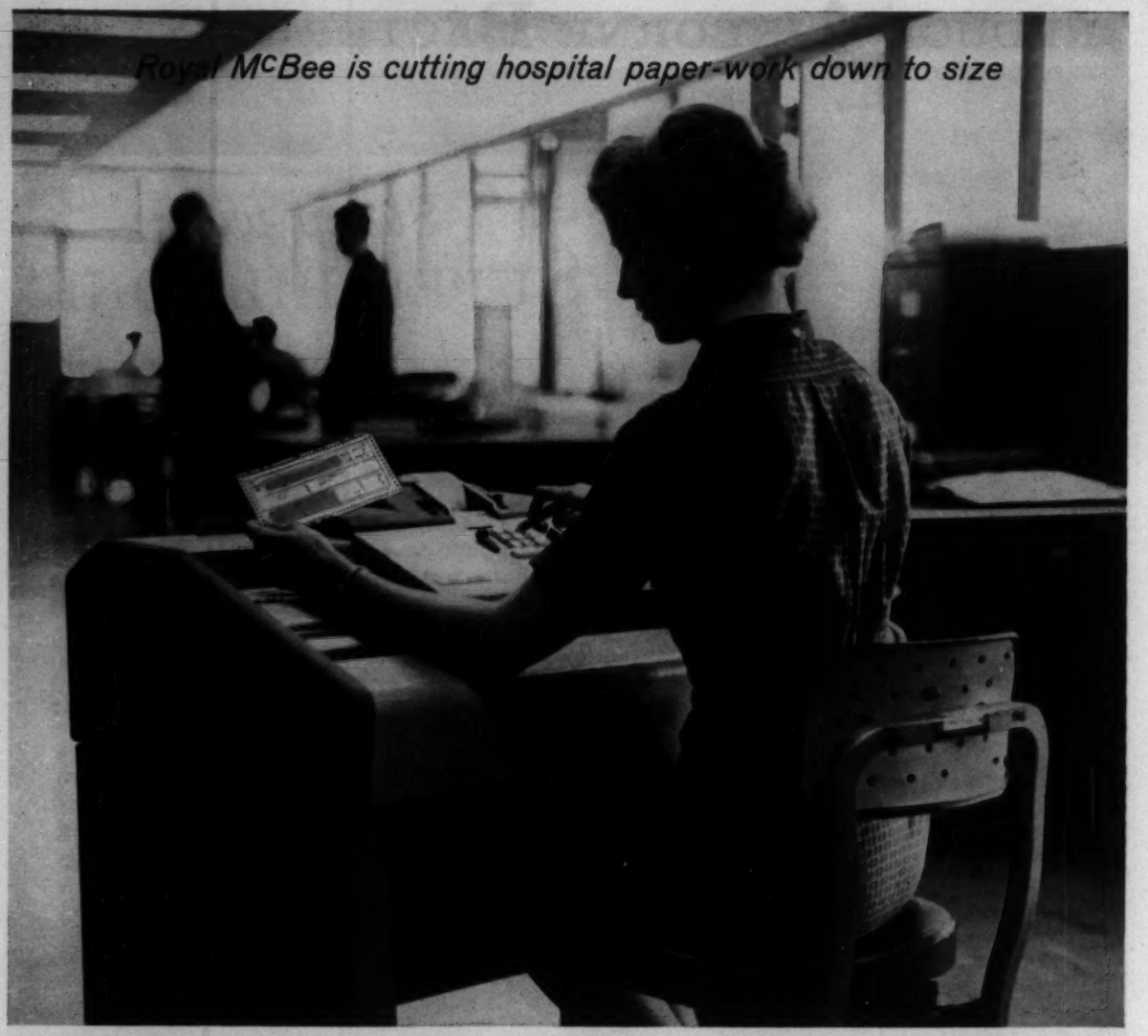

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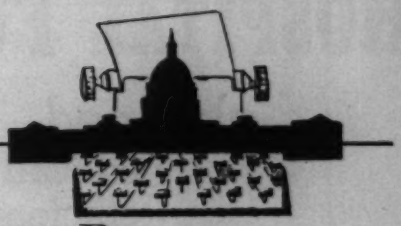

VA Medical Director Gives Progress Report

The problem of staffing Veterans Administration hospitals with adequate numbers of qualified physicians and nurses has become less critical in the past year, according to testimony of William S. Middleton, M.D., VA's chief medical director.

Dr. Middleton told the Subcommittee on Hospitals of the House Committee on Veterans Affairs that VA reduced the number of vacancies in its professional nursing staff in the fiscal year 1959 and again during the first half of fiscal 1960. VA now employs 14,430 full-time professional nurses, he said, and has only 334 unfilled positions.

VA also employs 4664 full-time physicians and at present has 327 vacancies for such posts.

Dr. Middleton testified that ". . . the acceptance of lay managers in the Veterans Administration is general". VA has a total of 45 lay managers, including the managers of the three largest VA hospitals.

In two days of testimony before the House subcommittee, Dr. Middleton outlined the progress of many VA hospital programs and answered questions on several key issues from subcommittee chairman, Rep. Elizabeth Kee (D-W. Va.), and subcommittee members. A summary of the major points made by Dr. Middleton follows:

Cost of Care: The cost of medical care in VA hospitals is higher than in private institutions, but somewhat lower than in state hospitals. The cost differences are difficult to analyze because of many variables in the elements of care.

Cost of Drugs: VA spends approximately $24 million a year on drugs. "The cost of drugs has increased materially, but largely because of the introduction of new drugs," Dr. Middleton reported. He added that drugs shorten the length of care needed for neuropsychiatric patients and result in an over-all cut in the cost of such care.

Size of Hospitals: The ideal size of a general VA hospital, according to Dr. Middleton, is approximately 500 beds. In Dr. Middleton's view, a 750-bed general

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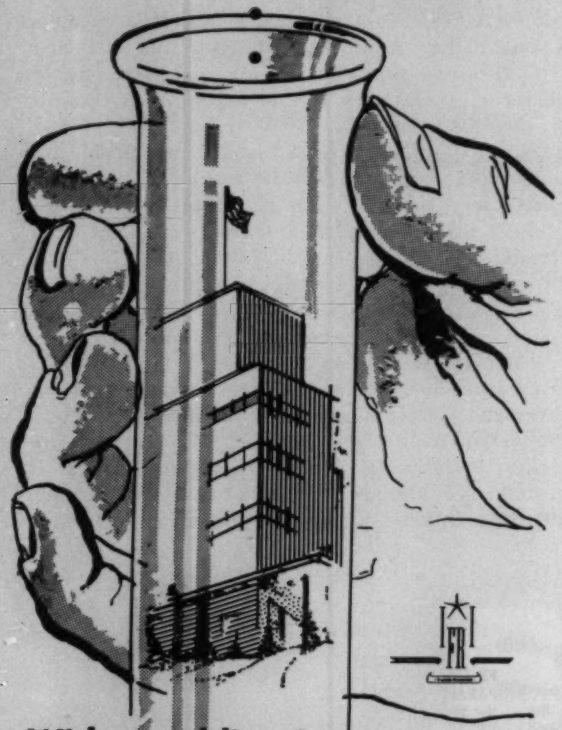

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hospital is "cumbersome". He predicted that neuropsychiatric hospitals in particular will become smaller in the future.

Care of Chronically Ill: Dr. Middleton said the care of veterans with chronic illness was "an ever increasing load". He said: "We are presently stretched as far as we can be stretched and give the quality of care the American people expect us to give." Dr. Middleton expressed the hope that other agencies will avail themselves of the Hill-Burton program for the construction of more nursing homes to relieve the problem.

The Forand Bill: Under questioning by Rep. Robert A. Everett (D-Tenn.) on how the Forand bill would affect VA care, Dr. Middleton replied that if the bill were enacted into law, VA's present 125,000-bed limit would eventually become adequate for all eligible veterans. Under an order by President Eisenhower a year ago, VA's hospital plant was set at 125,000 beds. All veterans with service-connected disabilities are eligible for care, but nonservice-connected cases may receive care only if beds are available.

Renovation and Maintenance: Dr. Middleton said that if Congress supports President Eisenhower's budget request for a 12-year renovation program of VA hospitals, all of VA's deferred maintenance projects will be liquidated by 1963. All pre-World War II buildings would be replaced, but postwar buildings would then require attention.

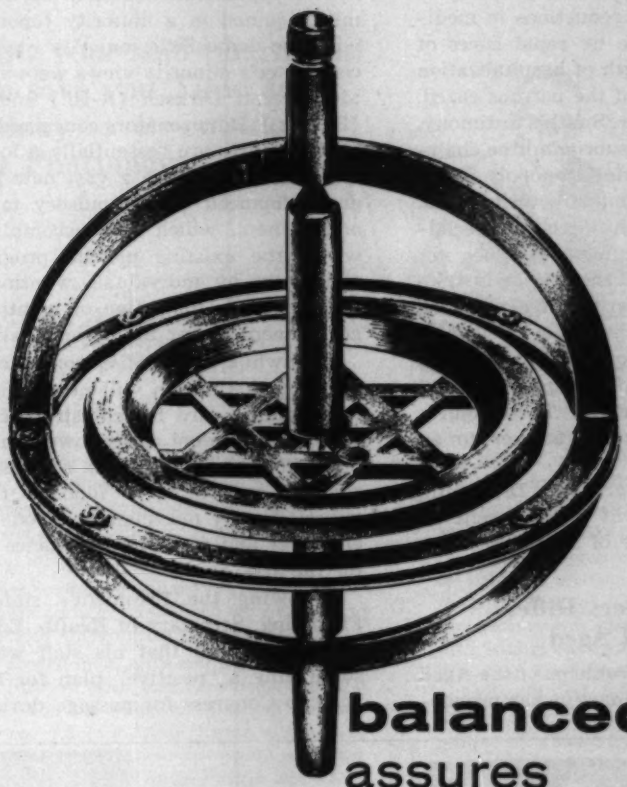
Hospital Laundries: VA will no longer construct laundry facilities in new hospitals if competitive bids for outside laundry service are available in the area. This is in line with the Eisenhower administration policy to restrict the federal government in small business enterprises. Dr. Middleton said that although VA's medical staff recommended that laundry be done within the hospital itself, outside laundries have serviced five VA hospitals on a trial basis for the past 18 months and no unfavorable reports on the spread of staphylococcal infections, on wear and tear, or quality of service in general have been received.

Industry Association President Testifies at Drug Hearings

The Senate Anti-Trust and Monopoly Subcommittee continued its hearings on the drug industry. The key witness at this phase of the much publicized hearings was Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association. He told the Senate subcommittee that Americans "would be paying a billion dollars a year more for drugs if the price of medicine in the past few years had gone up only as much as the total cost of living".

Dr. Smith said the drug industry has "an outstanding record of low prices maintained in an inflationary period". He declared, furthermore, that "on the basis of the record," he knows of "no other American industry that has contributed more from its resources to the public welfare", adding that "since 1947 this industry has spent about $1 billion in research alone."

Emphasizing the "staggering investment" which the drug industry puts into research, Dr. Smith said that "the chance that any given research involving a new potential medicine will be successful stands



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at 2865 to 1 against the manufacturer".

Every major advance of the United States drug industry has been accompanied by "astronomical dollars-and-cents savings to the American people", he maintained, explaining that vast reductions in medical expenses were made possible by rapid cures of illnesses resulting in shorter length of hospitalization and increasing the productivity of the persons cured.

Taking sharp difference with Dr. Smith's testimony, Sen. Estes Kefauver (D-Tenn.), subcommittee chairman, charged that there is a greater monopoly in the drug industry than in any other manufacturing area.

Senator Kefauver said the high degree of specialization by the larger drug manufacturers does not permit true competition. He called the drug industry's concentration of production "by far the highest I have seen in any industry".

Senator Kefauver said his committee's figures showed that the 22 largest drug firms spent only 6.4 per cent of their income on research. These figures were supplied by the companies in answer to an official questionnaire, he said.

This conflicted with testimony given by Dr. Smith, who said the drug industry spent 9.5 per cent on research, compared to an average of 3.2 per cent for all other industries.

Subcommittee Members Differ on Health Care of Aged

The Senate Subcommittee on Problems of the Aged and Aging released in mid-February a comprehensive report with 12 recommendations which placed major emphasis on a government program to finance health care for social security recipients.

Two republican members of the Senate subcommittee joined in a minority report which disagreed with the democratic majority recommendations. The committee's minority views were submitted by Senators Everett Dirksen (R-Ill.) and Barry Goldwater (R-Ariz.). Both senators concurred that the problems of the elderly are "essentially a local responsibility", and that "to propose a vast new governmental program, financed by compulsory taxation of mothers and fathers, which will accomplish no more than would the existing private programs, freely subscribed to by individuals wanting to take care of themselves, is indicative of wanting greater federal government power for power's sake alone".

Meanwhile, speculation continued that the administration this month will present a federal approach to providing care for catastrophic illness of elderly persons. President Eisenhower said at a February press conference that his administration was considering a proposal to increase the social security payroll tax by one-quarter of one per cent for both employer and employee to finance better health care for the aged.

Following the President's statement, Arthur S. Flemming, Secretary of Health, Education, and Welfare, announced that his staff was still hopeful of submitting a "positive" plan for health care of the aged to Congress for passage during this session.

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(Advertisement)

The Administrator's Hidden Asset

How your staff pharmacist can save you Time and Money—even outside the Pharmacy

by Alfred A. Mannino
EXECUTIVE DIRECTOR, HOSPITAL DEPT.
McKESSON & ROBBINS, INC.

Mail response to recent articles in this space has indicated increasing interest in the expanding role of the pharmacist in modern hospital administration. Those who have expressed their own experiences and opinions may be particularly interested in this recent personal experience of my own.

ABOUT a year ago I had lunch with the Administrator of a medium-size Southern hospital. We discussed knotty problems facing hospitals in general. Then we got down to brass tacks and tackled *his* problems.

My friend simply needed more arms and legs! He was besieged with administrative work, and his nursing staff was also overburdened. The old solution, "Just put on your other hat and do your other job," didn't seem to work any longer. More help was needed, there just wasn't any more money—and to increase hospital rates—was a last resort. But he was toying with another possible solution:

"What would you say," he asked, "if I turned some administrative work over to my Pharmacist?"

"I'd say 'Great'!" I enthusiastically replied. "I've seen it work beautifully in hospitals of all sizes—including some that were wondering if they could afford a Pharmacist at all! You see, most Pharmacists graduating today have more than Pharmacy behind their diplomas. They've also studied Drug Marketing, Pharmacy Management, Accounting and Law—as well as Principles of Economics. Older pharmacists have soaked up the same, handling the complex operations of their regular jobs. And I've noticed that most pharmacists, young or old, welcome opportunities to expand responsibilities—and so become more valuable. I think Central Supply would be a good place to start."

My harassed friend needed no further encouragement to start things rolling. So, before leaving town, I briefed our local McKesson Hospital Service Representative and he pitched in with every possible aid.

He also kept me in touch with the situation, but I was eager to see first-hand. So, recently, I returned to the sunny South. Results were so gratifying that I submit them now:

1. Reactions of the hospital staff to the new regime might have presented problems—but not to my Administrator friend. For instance, the veteran nurse who had been doing a conscientious job in Central Supply, first felt she was being demoted. But when the Administrator pointed out his need for ALL her time as Supervisor of Nurses, she brightened up—became fully reimmersed in work *really* close to her heart—and was all for the new setup.

Then, when the Pharmacist (aided by McKesson's local Hospital Service Representative) reorganized Nurses' Stations—ending unbalanced stocks, sudden shortages and frequent back-tracks to Pharmacy, he definitely became Best Friend of the Working Girl—and of everyone else interested in simplifying routines.

2. But the best was yet to come! Taking advantage of McKesson's *full-line* medical stocks and other supplies, the Pharmacist reorganized Central Supply inventory. The better balanced inventory filled all needs fully—without overstocking. Risk of loss through product deterioration or obsolescence was lessened, valuable space was saved—and stock issuing was greatly simplified. Supporting this was the "Rex" McKay® Service—sure to fill all orders intelligently, quickly and with strict adherence to brand specifications. McKesson is, of course, proud of its role in promoting the growth of reliable leading brands.

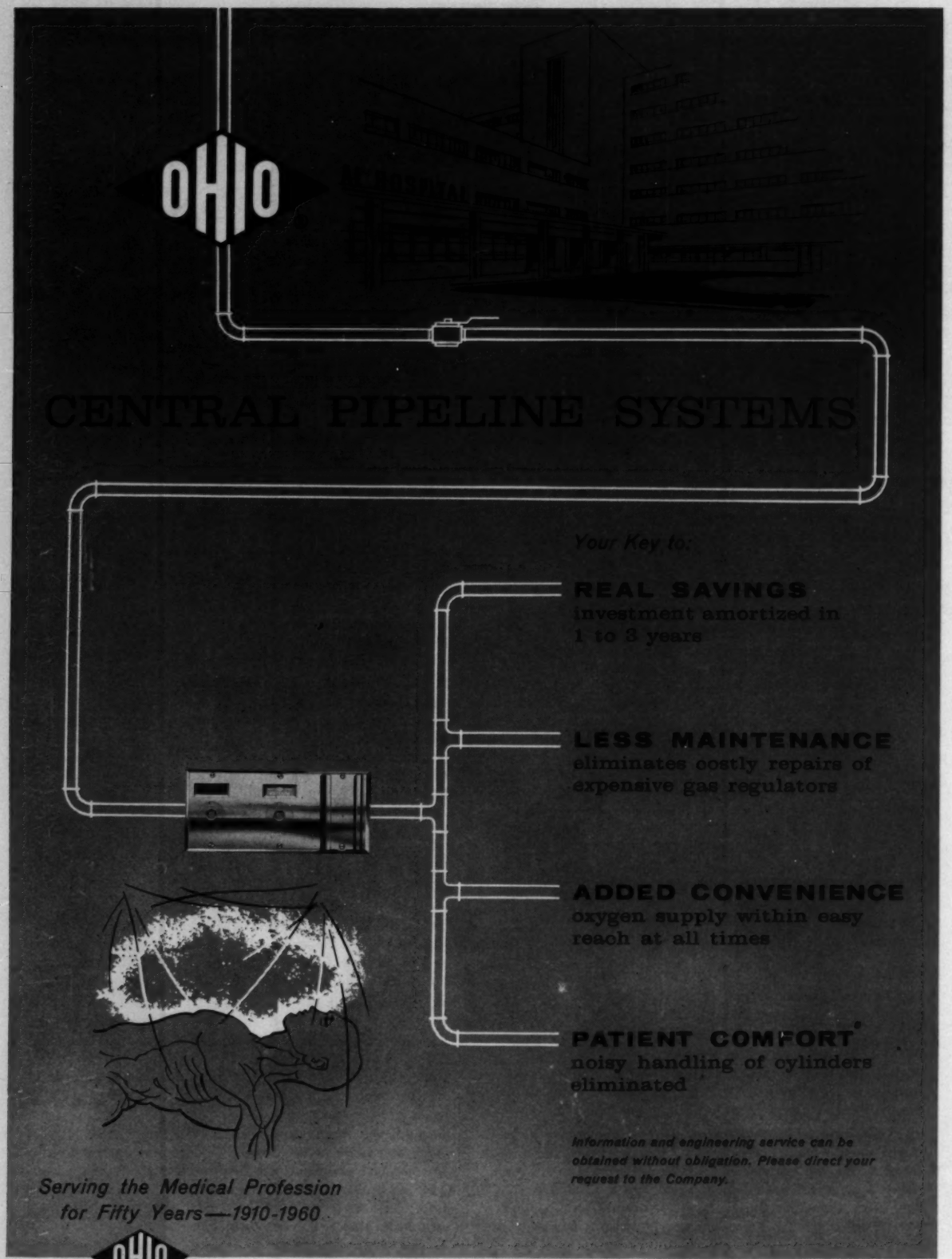
3. The local McKesson Hospital Service Representative also provided timely surveys. One showed that nurses desire more pharmacological information. Because doctors are often too busy to provide this, a pharmacological training program was set up, with the Pharmacist giving comprehensive talks on each new drug that came into the hospital. Everyone was enthusiastic about this program. The Administrator himself tried to get to every talk.

4. The biggest surprise was the Administrator himself. We had lunch together again, and I found myself seated across from an accomplished speechmaker. It seems he had been relieved of so many burdensome tasks that he initiated a community fund-raising campaign. He had spoken to civic leaders and business men, to church groups and women's clubs. Speechmaking had become so natural that at one point he addressed me as his "distinguished guest." He quickly caught himself and we had a good laugh.

What happened in this hospital is happening in many throughout the country. Administrators are saving time and money by extending the Pharmacist's management activities and purchasing contacts to other aspects of hospital administration. And they are improving hospital services by using the Pharmacist's professional ability in many areas outside pharmacy.

Perhaps this article should have been titled "The Hidden Asset That's Becoming Visible." More and more Administrators are learning to use the valuable asset they have—and an equally impressive number are learning they can afford to acquire such an asset. It's the new trend—and a wonderful illustration of hospital progress.

If you would like more information about how to better utilize a Pharmacist's management and professional assets, one of our McKesson Hospital Service Representatives will gladly help you. Simply address me: A. A. Mannino, McKesson & Robbins, 155 E. 44th St., New York 17, N. Y.



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AT PROTESTANT HOSPITALS CONVENTION—

Sixties Seen as Era of Enlightened Care of Chronically Ill; Care Standards Set

"The Sixties will be the era of enlightened care of the chronically ill," predicted Austin J. Evans, administrator, Hadley Memorial Hospital, Hays, Kan., at the meeting of the National Association of Methodist Hospitals and Homes in Columbus, Ohio, last month. This was one of the groups holding its meetings concurrently with the 39th annual convention of the American Protestant Hospital Association. Mr. Evans spoke at a crowded "Homes for Older Persons" section of the program.

Mr. Evans maintained that because of previous emphasis on care of the acutely ill and on preventive medicine, the chronically ill have either been neglected or fitted into the care patterns of institutions designed for the acutely ill. He advocated a concerted effort by all health care institutions, medical and nursing personnel and community and government agencies to care for the chronically ill.

To provide that care, Mr. Evans proposed a comprehensive rehabilitation center aided by general hospitals, medical personnel and community resources. Coordination of the program through such a center, designed for full evaluation, intensive care and treatment, will provide much better care for the chronically ill than is presently available, Mr. Evans said. Cooperation among the center and general hospitals and other health agencies will insure proper follow-up care, he added.

CHRONIC DISEASE NURSING

Standards for nursing care at the chronic disease level were recommended by Mr. Evans. He listed them as:

1. Quality care for the individual based on his needs and medical prognosis.
2. Total care for the individual as a person who has social and spiritual needs as well as physical needs.
3. An edequate evaluation of his needs by skilled specialists from various disciplines, social as well as medical.
4. Health care personnel with understanding of the patient's needs and problems, who can also motivate him to help himself.
5. Highly trained therapists who can operate the modalities essential to rehabilitation.
6. An effort to produce vocational rehabilitation to return many of the chronically ill to their jobs.

Standards for nursing care at the nursing home level were discussed at the session by Mrs. Campbell Keith, administrator, Walker Methodist Home, Minneapolis. Mrs. Keith recommended that nursing care in the nursing home be categorized according to patient need and suggested a number of basic categories. These were:

1. Minimum care for usually ambulatory patients who require some help, such as incontinents.
2. Moderate care for semi-ambulatory patients, those who cannot get around without a cane, walker or wheel chair.
3. Maximum care for bedfast patients or for ambulatory (senile) patients needing unusual care.

Independent Firm Created to Study Costs, Set Reimbursement Rates in Maryland

A joint effort of government and health field interests in Maryland has resulted in the formation of an independent, nonprofit firm, which will analyze hospital care costs and report on them.

The newly chartered organization, Hospital Cost Anaylsis Service, Inc., will determine actual patient care costs by conducting systematic examinations of financial and statistical records at hospitals throughout the state. At present, studies of this kind are conducted separately by the Maryland State Department of Health and by Blue Cross. Economies are expected to result from merging these activities, the health department said.

The new organization was developed by the state health department, Blue Cross and the Hospital Council of Maryland. The idea of the service was presented last year to a Maryland legislative council investigating health care costs by Russell A. Nelson, M.D., director of Johns Hopkins Hospital and president of the American Hospital Association. Dr. Nelson at that time stated that he believed costs would remain an issue of public debate until a wholly impartial agency presented its testimony. He proposed the establishment of "an independent, nonpolitical commission of outstanding citizens who would function as a 'super board of trustees' for cost certification for Blue Cross and State payments."

The corporation formed last month will be controlled by a 10-man board of directors, who will serve without pay. Four of them will be appointed by the governor and will represent different geographical areas; one director will be designated by each of the following: The Maryland State Bar Association, the State Insurance Department, the State Department of Health, Maryland Hospital Service, Inc. (Blue Cross), the Maryland Association of Certified Public Accountants and the Maryland Hospital Council. Other directors may be added from time to time, the health department announcement said.

The cost figures determined by the analysis service will be used by the state as the basis for payment for the care of indigent and medically indigent and by Blue Cross for determining hospital reimbursement rates. The organization was established following a directive of the Maryland governor to the health department that adequate procedures be adopted to insure effective use of state funds for indigent care.

The health department, Blue Cross and the hospital council will share the cost of the new service. ■

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CLEANLINESS AND ISOLATION, since the middle of the 19th century, have proved to be cardinal principles in the treatment of wounds.

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New S-E® Pack opens in one simple motion. Keeps dressing sterile from package to patient —never touches torn, unsterile edges.

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Examine one soon. You'll find its value is immediate—and immeasurable—in the fight against staph infections.

Saves time, labor and money

With this surprisingly simple wrap, one motion of the hand opens the package and presents a completely aseptic gauze or cover sponge. It touches neither hands nor unsterile surfaces, not even a torn edge of the package. No strings, no scissors. You merely pull a tab.

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You simply peel back one flap and the sponge is ready. You have complete control. Dressing is tucked in pocket . . . easy to hold, easy to reach. And one hand is still free. Curity now provides Cover sponges in 4" x 3" and 4" x 4", and a gauze sponge in 4" x 4" in the new S-E Pack.

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THE PRE-WRAPPED, PRE-STERILIZED DRESSING improved technique and convenience, saving time and labor.

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4. Exceptional care for patients who require special services, equipment or facilities.

Government participation in health and welfare programs was discussed by Arthur S. Flemming, Secretary of Health, Education, and Welfare, at the first general assembly of the Methodist association.

On the problem of dependent children, Mr. Flemming said that refusing them aid was not the solution. Instead, he recommended more basic measures, such as elimination of slums, furthering of equal educational opportunities, strengthening of family ties and adding emphasis to spiritual life.

To eliminate or prevent dependency at other age levels, he recommended a stepped-up, federal-state rehabilitation program.

In addition, Mr. Flemming recommended an "independent living rehabilitation services" program for disabled, nonhospitalized persons living at home. "The time has come for the federal government to take the initiative in this," Mr. Flemming said, "and legislation will be presented to this session of Congress."

LEGAL DISPUTES MIGHT ARISE

The use of both a "general" and a "special" consent form was recommended to hospitals by John F. Horty, associate research professor and director, Health Law Center, Pittsburgh. Mr. Horty spoke at a session of Southwide Baptist Hospital Association section of the APHA convention. The use of consent forms was mentioned by Mr. Horty as one of the areas in hospitals where legal disputes are most likely to arise.

The use of the two consent forms was necessary, Mr. Horty said, "because of the trend toward liability without fault." The general consent form, he explained, to be signed by the patient at the time of admission, protects the hospital and the physician against charges of assault and battery.

The special consent form covers authorization for medical and surgical diagnostic and treatment procedures, he said. This form should be signed in duplicate by the patient in the physician's office prior to surgery or medical treatment, he said, and should be countersigned by the physician, who should keep one copy on file in his office and forward the other to the hospital. Since the patient consents only to what he understands at the time of the consent, Mr. Horty said, the physician should obtain the patient's signature at the time the need for and the nature of the proposed treatment are explained.

ELECT OFFICERS

The American Protestant Hospital Association at its Columbus meeting elected and installed the following officers: president, Frank R. Bradley, M.D., administrator, Barnes Hospital, St. Louis; president-elect, Rev. A. H. Schmeuszer, administrator, Evangelical Deaconess Hospital, Milwaukee; first vice president, H. L. Dobbs, administrator, Kentucky Baptist Hospital, Louisville; second vice president, Brig. William Chamberlain, Salvation Army, Cincinnati, and treasurer, C. E. Copeland, administrator, Missouri Baptist Hospital, St. Louis. ■

AMA Announces New Rules on Foreign Graduates

Four rules governing the participation of foreign medical graduates in approved internship and residency programs of United States hospitals have been announced by the Council on Medical Education and Hospitals of the American Medical Association.

These rules implement the 1958 policy statement of the AMA, which established July 1, 1960, as the date by which all graduates of foreign medical schools serving as interns or residents should be certified by the Educational Council for Foreign Medical Graduates.

The new policy, approved at last month's Congress on Medical Education and Licensure, states that after the July deadline "no hospital should expect to maintain an approved internship or residency program unless its appointees who are graduates of foreign medical schools either:

- "Have a full and unrestricted state license to practice,
- "Are in their final six months of training,
- "Have secured a standard or temporary certificate from ECFMG, or
- "Have been given a contingent appointment for not more than six months based on their having been accepted for the September 1960 American Medical Qualification Examination of the ECFMG. Extension of the appointment beyond Dec. 31, 1960 will be dependent upon the appointee receiving temporary or standard certification from ECFMG as a result of this examination."

The AMA council advised hospitals making contingent appointments on or after July 1, 1960, to state in contracts or agreements with foreign medical graduates that the appointment will be terminated on or before Dec. 31, 1960, if the appointee fails in the September qualification examination, and that the hospital will notify the U.S. Immigration and Naturalization Service of this termination.

If the appointee fails in September, the hospital should notify INS and the AMA council of the appointment termination date if the foreign graduate is in this country on a temporary or student visa. It should also notify the council if the graduate has a permanent immigrant or citizenship status.

The AMA council noted that federal law requires institutions to notify INS of appointment changes of nonpermanent residents. ■

Colorado Supreme Court Holds Hospitals Exempt from State Labor Act Provisions

Exemption of charitable hospitals from the provisions of the Colorado Labor Peace Act was decreed February 23 in a five to two decision of the Colorado Supreme Court. The act, if found to apply to voluntary hospitals, would have required these institutions to permit their employees to vote in union representation elections and would have compelled collective bargaining under certain conditions.

The majority opinion, written by Justice Albert T. Frantz, stated that "the policy of this state cannot sanction interference with or the disruption of the essential operation of a hospital by the concerted action of its employees."

The controversy began last year when the Building Service Employees International Union Local 105 attempted to organize nonpro-

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fessional employees at St. Luke's Hospital, Denver. Attorneys representing the hospital and Colorado Hospital Association instituted court proceedings after the Colorado Industrial Commission held it had jurisdiction under the Labor Peace Act to conduct a bargaining election at the hospital.

Last May, a district court judge found the labor act to apply to charitable hospitals. The supreme court, however, reversed that earlier decision, stating that "employees of hospitals, whether professional or nonprofessional, enjoy an employment status quite unlike most other employment relationships.

"To vest any organization with a power to imperil the operations of such an institution is to give power which no organization should want, or having it, should exercise," Justice Frantz wrote. The possibility of hospital strikes was given by the justice as an important reason for the majority decision.

The minority, represented by Justices William E. Doyle and O. Otto Moore, charged the majority with "seeking to legislate in accordance with its own views."

The Colorado labor act, as enacted in 1943, covers persons employed by firms with eight or more workers, excluding only state and public employees, farm and domestic workers. The supreme court majority justices conceded they considered the "intent" of the legislature and said they interpreted the legislation to mean that operation of hospitals was not within "industrial activity" as defined in the act.

Justice Doyle, writing for the minority, pointed out that as a result of the supreme court decision, voluntary hospitals in Colorado "are deprived of whatever protection procedures afforded by the act provide against irresponsible and ill-considered action by organized employees." Organization, collective bargaining and even strikes by employees will not be prevented by leaving them outside the act's provisions, he maintained. ■

AT FORUM OF INSURANCE COMPANIES—

Federal Employees Health Program Seen As Step in Voluntary Insurance Growth

Application of the principle of the Federal Employees Health Benefits Act to the problem of health care for the aged received considerable attention at the Health Insurance Association of America's 1960 Group Insurance Forum, held in Chicago last month.

The act was described as a "splendid example of cooperation" between government and business by V. J. Skutt, president of the association. The HIA is an organization composed of more than 265 insurance companies which provide 80 percent of the health insurance written in the United States by commercial insurers.

The method in which the federal employees health program is administered "has spared the government itself the necessity of setting up and administering a health in-

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Scientific Housekeeping: Your Most Effective Weapon Against Staph

Can applied engineering techniques coupled with improved sanitation and housekeeping methods achieve complete bacterial control? Puritan Engineered Maintenance may be the answer.

RECENT CONFERENCES and studies of leading hospital and medical associations have pointed to the fact that the only effective way to prevent and control cross infection is through the use of scrupulous sanitation methods in all areas of a hospital.

Preventive sanitation methods are needed

Past reliance on antibiotics has not proved successful against staph. There is general agreement that preventive sanitation measures are far more reliable—and more economical—than corrective medical measures. While the theory of preventive sanitation is the ideal, there still remains the question of how the ideal should be achieved.

A wide range of sanitation products available

The first and most logical step in setting up an effective hospital sanitation program would seem to be the selection and use of the right product for any specific area. Hospital sanitation products range from simple detergents to a wide number of disinfectants, bacteriostats, germicides and antiseptics. These might be incorporated into wall, ceiling and floor cleaners, waxes, window cleaners, air sanitizers or treatments for cooling water and air conditioning filters.

Proper use is important

But, the selection of the right product is only part of the battle. About 90% of the success of any effective anti-cross infection program can be attributed almost directly to the proper use of these products and the frequency with which they are applied.

The point is that bacterial growth follows a definite pattern. At first the rate of growth is relatively slow. Then, it becomes fantastically rapid. The source of infection may be the air or it might be exposed surfaces. Cleaning floors, walls, furniture and windows with a detergent-germicide will immediately reduce the bacteria count and slow down the rate of redevelopment. Using a detergent-germicide in conjunction with an anti-bacterial floor finish will reduce the count even further and lengthen the time in which bacteria growth starts again. Successive use of bacteriostat-treated mops, bacteriostatic furniture polishes and window cleaners, air sanitizers and similar products will further lower the mean bacteria count and will simultaneously reduce the rate of redevelopment. Thus, time, frequency and method of application all have an extremely important bearing on the results achieved in an effective sanitation program.

Puritan Engineered Maintenance starts with the prime essentials

In basic terms, time, frequency and method are directly concerned with labor. These essential factors are, in fact, the heart of Puritan Engineered Maintenance, a scientifically determined housekeeping program for hospitals.

When a Puritan ENGINEERED MAINTENANCE Program is installed, the following steps are undertaken: (1) Desired levels of sanitation are determined for every area; (2) Cleaning frequencies needed to maintain these standards are established; (3) Custodial and supervisory responsibilities are assigned; (4) Custodians are trained in the use of proper materials, equipment and methods; (5) Regular inspections are made to see that the predetermined standards are maintained.

Proper use before proper product

After these steps have been outlined, the proper products are selected. Thus, through the proper combination of products and scientific cleaning methods, the mean bacteria count can be lowered to practical and safe levels where the danger of staph is virtually eliminated.

Hospital-wide sanitation important

Sanitation must, however, be a hospital-wide operation. It should be programmed into all areas, including lobbies, patient rooms, operative areas, kitchens, public wash rooms, laundries, offices, etc.

How to install a program

To the average administrator and housekeeping staff, developing and establishing such a program is a tremendously involved undertaking. However, there is a way in which a scientific housekeeping and sanitation program can be established—and with only a minimum of time and trouble. The answer is to let Puritan inspect your hospital, review your present sanitary maintenance procedures and submit and install an individually planned ENGINEERED MAINTENANCE Program for you. As a user of our sanitary maintenance products, you get this service absolutely free.

How to obtain information

For further information on prevention and control of cross infection, write for the November-December issue of Puritan's "Maintenance Matters" in which the concept of total bacteria control is discussed. Also, ask for a copy of our brochure "ENGINEERED MAINTENANCE". Puritan Chemical Company, 916 Ashby Street, N. W., Atlanta 18, Georgia.

surance program for employees", Mr. Skutt said. He then suggested, "It is possible that in the application of this principle could be found the answer to certain areas of coverage for the aged which now seem to present a problem. Thus, the program could be placed in its proper sphere—service, not politics."

AGED AND INSURANCE GROWTH

Commenting on the report of the Senate Subcommittee on the Problems of the Aged and Aging, Mr. Skutt said that the subcommittee "has made recommendations that fail to recognize in full the tremendous development and growth of voluntary health insurance for the aged."

The provisions of the act were explained by L. M. Cathles Jr., vice president of group division of Aetna Life Insurance Company, the company chosen as carrier of the indemnity benefit plan, one of the plans provided for in the act.

In pinpointing the significance of the act to the voluntary health insurance system, Mr. Cathles declared: "Perhaps the most significant point of all... is that the government made use of existing insurance facilities for providing health benefits and did not establish a special bureau to provide these benefits."

The effect of competition on major medical insurance was discussed by A. B. Halverson, second vice president, Occidental Life Insurance Co. of California, Los Angeles.

One of the primary reasons for financial difficulties with major medical insurance has been "the general competitive situation which has had an adverse effect upon the initial major medical rate tables," he said. "If we are paying the same benefits, how can one company possess the genius over the previous carrier to insure the same group for less premium than the former carrier required?" he asked.

The co-insurance feature was described by Mr. Halverson as "still the one best way to make a person feel the cost of abuse by making him aware of unnecessary expenses by way of his pocketbook." ■

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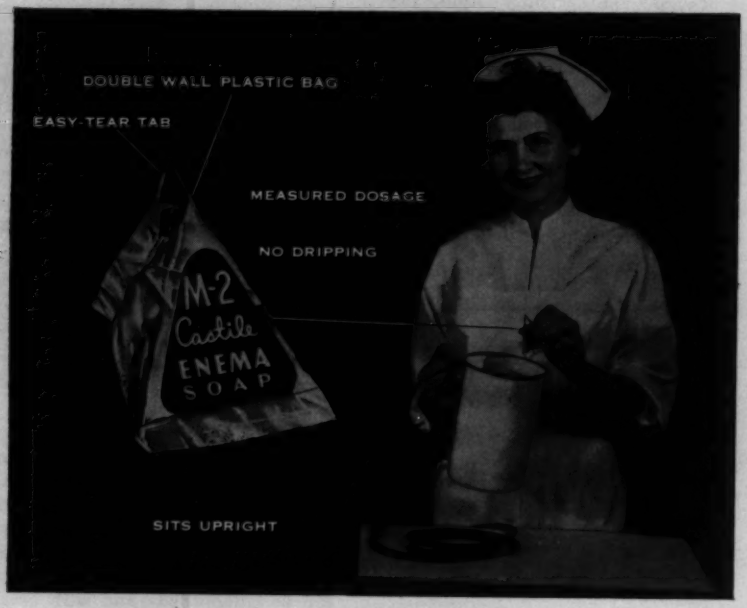

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U.S. Supreme Court Rules Against Arkansas Hospital

An Arkansas proprietary hospital failed recently in its last effort to have the exclusion of its chief of staff from a medical society judged a conspiracy in violation of the Sherman Antitrust Act.

The U.S. Supreme Court refused to review the suit of Elizabeth Hospital, Prairie Grove, Ark., against the Washington County (Ark.) Medical Society and four of its members.

The hospital filed a $300,000 claim after the medical society refused to admit Dr. Frank Riggall, the hospital's manager and chief of staff, as a member. The hospital plaintiff claimed that this action so diminished Dr. Riggall's professional standing that it reduced the number of patients, local and out-of-state, using the services of the hospital. The hospital's suit also pointed out that purchases of medical equipment and supplies were made from out-of-state sources by the institution.

In July 1959, a Federal Court of Appeals found that the medical society's decision did not have any substantial restraining effect on interstate commerce, concluding that "the fact that some of the plaintiff's patients might travel in interstate commerce does not alter the local character of the hospital." ■

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1. Grossman, L.: Archives of Pediatrics, 71: 173—179, June 1954.

ANOTHER FINE PEDIATRIC SPECIALTY BY BREON.

University of N.C. to Study Hospital-Physician Relations

R. R. CADMUS, M.D.

North Carolina Memorial Hospital of the University of North Carolina, Chapel Hill, has received a $114,494 grant from the National Institutes of Health that will finance a four-year research project entitled, "Improving Hospital-Physician Relations Through Education."

Robert R. Cadmus, M.D., director of the hospital and professor of hospital administration at the university's School of Medicine will serve as the principal investigator.

The purpose of the study is to develop within the existing medical curriculum an effective program of instruction which will give the maturing medical student a better understanding of the administrative implications of the practice of medicine, particularly in the hospital setting. The project also concerns local curriculum planning. New information will be incorporated into present teaching patterns, Dr. Cadmus said.

The four-year study is the first major research project designed to concentrate on the interprofessional relationships, a university spokesman said. He also expressed the hope that with increased knowledge and with the development of sound and mutually acceptable concepts, these relationships can be strengthened on a national level. ■

Von Ehren Chosen Director for Wisconsin Association

Warren Von Ehren this month became the executive director of the Wisconsin Hospital Association. His office will be in Madison at 219 Washington Bldg., Mr. Von Ehren began his career in the hospital field at Hines, Ill., Veterans Administration Hospital. He was then assistant superintendent of Bronson Methodist Hospital, Kalamazoo, Mich., and until this month had been administrator of Bellin Memorial Hospital, Green Bay, Wis. Mr. Von Ehren twice held the position of administrative assistant with the American Medical Association. A member of a number or professional societies, Mr. Von Ehren has a B.S. degree and a master's degree in hospital administration from Northwestern University, Evanston, Ill. He is a member of the nursing home advisory committee of the Wisconsin Board of Health, and chairman of the small hospitals section of the Tri-State Hospital Assembly. ■

Pendall Accepts Executive Post with Maryland Council

Rudolf J. Pendall has been appointed executive director of the Hospital Council of Maryland, Baltimore, an association of 38 Maryland hospitals. Prior to his arrival in Baltimore, he had been associated with Columbia University in the preparation of a textbook on hospital administration. He was formerly executive vice president of a public relations firm specializing in the hospital field, and had also been editor of *Hospital Progress*.

MR. PENDALL

Mr. Pendall graduated from the University of Wisconsin and also holds a master's degree in administrative medicine from Columbia University. ■

Harrisburg Plan Program Aims at Subscriber Education

An educational campaign aimed at calling subscribers' attention to the fact that use of their hospital benefits determines Blue Cross rates has been launched recently by Capital Hospital Service, the Harrisburg, Pa., Plan.

The Plan's 1959 experience, which showed an increasing rate of admission, prompted the effort to tell subscribers the hospital utilization story.

The Plan's year-end statement showed that $1 million more was paid for hospital care of members in 1959 than in the previous year. The rate of admission per 1000 members rose to 122.2 from 120.9 in that period.

The educational campaign was initiated with an article in the Plan's newsletter, directed to leaders of member groups. The article was followed by the distribution of bulletin board posters and pay check stuffers for use by subscriber groups. Nongroup members received the message directly from the Plan in the form of bill stuffers. Newspaper advertisements and radio messages on the theme, "Don't Waste Your Blue

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Cross Services", were also used.

In addition, physicians in the central Pennsylvania area were furnished wall cards setting forth Blue Cross benefits and urging their patients not to ask for unnecessary hospital services. ■

James Souder Heads Research in Planning Project

The appointment of James J. Souder as project director of the Collaborative Research in Hospital Planning Project was recently announced by Dr. Edwin L. Crosby, director of the Hospital Research and Educational Trust.

The hospital planning project is a joint undertaking of the American Hospital Association and the American Institute of Architects under the sponsorship of the Trust. The purpose of the project is to determine guiding principles for hospital construction.

Mr. Souder, a partner in the New York City architectural firm of Kiff, Colean, Voss and Souder, is a member of the American Institute of Architects and the Building Research Institute. He holds a bachelor of architecture degree from Massachusetts Institute of Technology, where he also did graduate work in city planning.

Fred McNamara Retires From U.S. Budget Bureau

Fred A. McNamara retired this month as chief of the Hospital Division of the U.S. Bureau of the Budget. He will devote his entire time to hospital consulting. In addition to his work for the federal agency, he has been doing some private consulting for the past 10 years. Mr. McNamara is establishing his own business in Washington, D.C., and will also continue to be associated with a consulting firm in Minneapolis. Mr. McNamara was in federal service for 38 years, and spent 28 of them in hospital work.

Rise in Outpatient Cases Noted by N. J. Blue Cross

Outpatient departments of New Jersey hospitals are treating more than three times as many Blue Cross patients as they did five years ago, the Hospital Service Plan of New Jersey reported last month.

Last year, 100,261 outpatient claims were paid, compared to 32,965 in 1955. The 1959 increase in outpatient cases paid by Blue Cross was 27 per cent over the previous year, while admissions in

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that year increased only 4 per cent.

A growing emphasis on the development of outpatient facilities by hospitals was given by Blue Cross officials as the main reason for this trend. Hospitals, the Plan pointed out, benefit by having more beds available for those definitely needing bed care.

The Plan quoted outpatient service benefits at $12 per case, compared to an average of $240 per admitted patient. Any check in admissions, therefore, could act as an important stabilizing influence on the Blue Cross rate structure, the Plan pointed out. ■

Simmons Acquires Hausted, Hospital Equipment Maker

Simmons Company, a Chicago furniture manufacturer, recently acquired the business of Hausted Manufacturing Company, designers and producers of a line of wheeled stretchers and other hospital patient handling equipment. Hausted became a division of Simmons, with Ray Hausted, formerly president of the company, as general manager of the division. The Hausted plant at Medina, Ohio, is retaining its personnel, Simmons Co. announced, and the operation of Hausted has remained unchanged.

Wilmot Castle Resigns As Head of Supply Firm

Wilmot V. Castle announced his retirement as president of Wilmot Castle Company, manufacturer of lighting and sterlizing equipment, at year-end 1959. He had been active in the Rochester, N.Y., concern for 47 years. John H. Castle Jr., formerly vice president, succeeded his uncle as president.

Wilmot V. Castle, who was the second president of the manufacturing company, will become a member of the Castle board of directors.

Mr. Castle graduated from the University of Rochester (N.Y.), and attended Harvard University Business School before he joined the Castle company in 1912. He had played an important role in bringing about the company's entrance into the fields of dental sterilization and dental, hospital and medical lighting, the announcement from the Rochester company said. ■

Rockefeller's Legislative Aims Involve N. Y. Hospitals

In his annual message before the joint session of the senate and assembly, New York Governor Nelson A. Rockefeller made several points touching on hospital and health care problems, the *Legislative Bulletin* of the Hospital Association of New York State reported.

Minimum Wage. The governor recommended the adoption of a statutory minimum wage providing "a floor of one dollar per hour for all workers now subject to the minimum-wage law with only such exceptions as are clearly appropriate." His proposal would include the employees of nonprofit hospitals, the *Bulletin* said.

Insurance for Aged. On the problem of aging, Mr. Rockefeller said: "It is a tragic fact that at the retirement age of 65, people are frequently dropped from health insurance plans, only to find that the cost of individual coverage is prohibitive. I shall recommend legislation requiring the conversion at fair rate of group health policies to individual policies at the time of retirement."

The governor also said he hoped that during the present legislative session he would have available the results of three surveys of health care and prepayment in New York State currently under way.

Unemployment and Disability Insurance. The fact that "thousands of workers" in nonprofit institutions do not have social insurance protection (unemployment and disability) also received the governor's attention. Mr. Rockefeller said he proposed to consult with nonprofit institution representatives on this matter in order to develop proposals for legislative action. ■

Development Course Offered to Administrators by Cornell

A four-week hospital administrators development program will be offered at Cornell University, Ithaca, N.Y., from July 10 to August 5, 1960. This will be the third such program to be sponsored by the Sloan Institute of Hospital Administration at Cornell. The program will explore new developments in hospital administration and broaden administrators' points of view, the university stated. Approximately 25 hospital administrators will be selected for participation on the basis of applications received.

The program is composed of three seminars, on the subjects of medical care programs, the administrative process, and trends in hospital administration. Teaching

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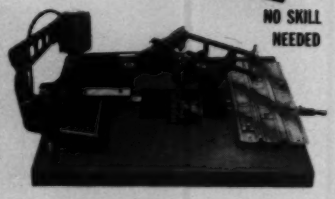

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staff for each seminar will include a resident faculty member and a visiting professor.

The total cost of $100 includes tuition, supplies, room, and most of the meals, the university said. Additional information and application forms are available from Sloan Institute of Hospital Administration, Graduate School of Business and Public Administration, Rand Hall, Cornell University, Ithaca, N.Y. ■

Columbia University Offers One-Year Study Program

A Program of Continuation Education for administrators of hospitals of 100 beds or less is being offered again by the Columbia University School of Public Health and Administrative Medicine, New York City. No college degree is required for admission, the university said.

The year-long study program consists of two two-week periods on the university's New York campus (June 1960 and 1961), correspondence work by the administrators, and monthly review meetings with the preceptor. Only administrators or chief executives of health care institutions who do not have a master's degree in hospital administration are eligible. Further details may be obtained from Harold Baumgarten, Program Director for Hospital Administration, Program of Continuation Education, Columbia University, 600 West 168th Street, New York 32. ■

Groups Elect Officers

Alabama Hospital Association: president, Donald G. Harms, administrator, DeKalb County General Hospital, Fort Payne; president-elect, Matthew F. McNulty Jr., administrator, University Hospital and Hillman Clinic, Bermingham; secretary-treasurer, Harold W. Steadham, administrator, George H. Lanier Memorial Hospital, Langdale.

San Francisco Hospital Conference: president, Joseph L. Zem, administrator, St. Luke's Hospital; vice president, W. P. Geigenmuller, superintendent, San Francisco-Stanford Hospital; treasurer, Sister Mary Rose, administrator, Mary's Help Hospital.

Western New York Hospital Council: president, Melvin E. McNab, administrator, De Graff Memorial Hospital, North Tonawanda; vice president, Leon C. Carson, superintendent, Millard Fillmore Hospital, Buffalo; secretary, Sister M. Paschal, administrator, Mount St. Mary's Hospital, Niagara Falls; treasurer, Frank H. Evans, vice president, Hospital Service Corporation of Western New York, Buffalo. ■

CONSTRUCTION | PLANNED AND COMPLETED

California

La Jolla—Scripps Memorial Hospital, a seven-story, 250-bed facility, will be constructed at an estimated cost of $4 million. The main unit will be serviced by a free-standing elevator tower. This design will permit future expansion with the addition of another nursing unit on the other side of the elevator.

Los Angeles—Los Angeles Orthopaedic Hospital, designed for the care and treatment of the physically handicapped, was constructed at a cost of $6.5 million. The six-story structure has provisions for 160 beds, six surgeries, emergency service, educational closed-circuit television, auditorium and schoolrooms. Other features include a rehabilitation center and hydrogymnasium, a cerebral palsy unit, arthritis service, and fractures and hand surgery departments.

Los Angeles—University of California at Los Angeles Medical Center is building a new $8 million wing which will house the Neuropsychiatric Institute and the Brain Research Institute. Scheduled for completion in October, the wing will have six stories for hospital activities and a 10-story, L-shaped laboratory wing. The Neuropsychiatric Institute, in addition to facilities for programs in psychiatry and neurology, will have a 188-bed hospital, a psychiatric and neurology clinic, and a day hospital. The 10-story brain research laboratory wing will include approximately 65 laboratories.

Los Angeles—Viewpark Community Hospital, a 99-bed institution, contains facilities for medicine, surgery, obstetrics and pediatrics. Patient accommodations and administrative offices are located on the street level, while most ancillary services are on the

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lower level. Total cost was approximately $1.7 million.

Torrance—Little Company of Mary Hospital, a five-story, 150-bed facility, was constructed at the cost of $3.5 million. It includes four operating rooms, a surgical ward, pediatrics department, labor and delivery rooms and obstetrical recovery wards. Provision was made for addition of three more stories.

Van Nuys—Midvalley Community Hospital, a 50-bed facility built at the cost of $700,000, includes x-ray and pathology laboratories, two operating rooms, an obstetrics department and a pharmacy. The building has a central corridor, with laboratories, surgery and obstetrics departments located in separate wings.

Colorado

Denver—National Jewish Hospital has added a $1.25 million research building. The seven-level facility has laboratories for experiments in biochemistry, immunology and pathology.

Denver—Sands House Sanatorium, an institution providing specialized nursing care for cancer patients, has added an eight-room wing at the cost of $40,816.

AT FALLBROOK, CALIF., construction has begun on 20-bed, one-story Fallbrook District Hospital. The four areas of the building will be linked by a central court onto which each patient room will open. The 11,000-square-foot building will have facilities also for six bassinets, a delivery and an operating suite. The roof will form a lid for the entire structure.

Illinois

Chicago—Louis A. Weiss Memorial Hospital is expanding its facilities at a cost of $2 million, with the building of an eight-story wing adjacent to the hospital. The new Maribel and Harry Blum Pavilion, scheduled for completion in September, will house the hospital's Jacob M. Arvey Clinic, and permit expansion of services to include a children's orthopedic clinic and specialty clinics in obstetrics and gynecology.

Chicago Heights—St. James Hospital has added a $500,000 service building and a six-story, 129-bed, $3 million wing, marking the end of the first phase of a $4.5 million expansion program. The wing contains offices, a pharmacy, an outpatient department, a surgical floor with nine suites, two general care floors, a pediatrics floor, an obstetrical department and nurseries.

Des Plaines—Forest Hospital, devoted to treatment of mental and emotional disorders, has added a 30-bed wing called "Country House." Designed to resemble a home, the "Country House" has Danish modern furniture, original oil paintings in every room and piped-in music.

Indiana

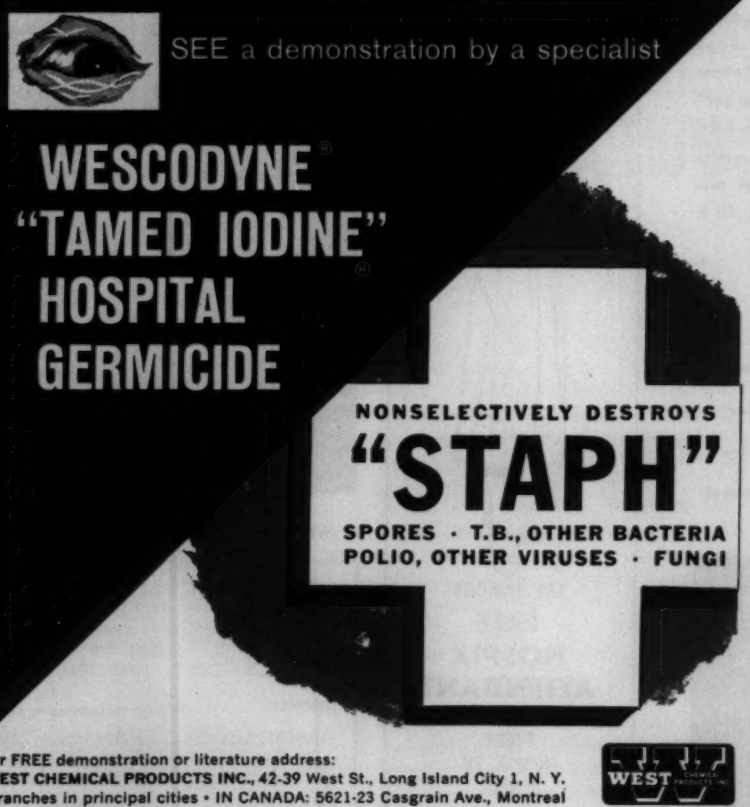
Newton County—George Ade Memorial Hospital of Newton County, a 38-bed county hospital, is under construction near Brook. The cost is estimated at $720,000.

Maryland

Baltimore—Church Home and Hospital ended the first phase of a $4 million development program with the completion of a $2.6 million wing. Construction of a students' dormitory and a school of nursing, and renovation of the older buildings will complete the project. The new seven-story wing houses 200 general beds, and includes 37 rooms for residents of the home for the aged. The new wing also houses an outpatient department, and a pharmacy. The permanent residents' area has a separate dining room and kitchen, a library, living room and an arts and crafts room.

New Jersey

Fort Dix—Charles M. Walson Army Hospital, a $10.5 million governmental facility, will care for personnel and dependents from the Fort Dix training center and the adjacent McGuire Air Force Base. The nine-story, three-wing structure, in addition to ward, service and administration areas, houses a



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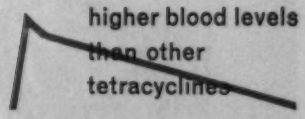

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maternity section, a psychiatric section with maximum security facilities, and several operating rooms.

Orange—New Jersey Orthopedic Hospital, a 65-bed, $2 million unit, is a new addition to the Hospital Center at Orange. The four-story structure houses orthopedic services, and also a cerebral palsy unit and a rehabilitation service for cardiac, arthritic and rheumatoid diseases.

New York

New York—Columbia-Presbyterian Medical Center is planning a $50 million development program. Approximately $35 million is intended for new construction and renovation projects: $21.5 million for one major building project consisting of an 18-story medical research building, a library, and a structure for nonmedical services; $3.2 million for a residence hall for married students, residents and research physicians; $2.4 million for renovation of laboratories and teaching facilities; $1 million for an auditorium; $2 million for Presbyterian Hospital renovation; $2 million for expanding physicians' offices; $2 million for modernization of Babies Hospital, and $800,000 to centralize x-ray therapy equipment.

New York—Phipps Houses, a charitable housing corporation, will erect, finance and manage an apartment building for approximately 170 New York Hospital residents and their families. An underground passageway will connect the residence building with the New York Hospital.

Poughkeepsie—Vassar Brothers Hospital has added a five-story cylindrical structure with facilities for 165 beds and 24 bassinets. Six more stories could be added to the $3 million building.

Suffern—Good Samaritan Hospital has added a 50-bed, two-story wing at a cost of $1.5 million. The addition has been named the Francis Cardinal Spellman Pavilion.

Oregon

Portland—Mt. Tabor Convalescent Hospital, a 55-room, 125-bed facility, was built to serve pre- and postoperative cases, the chronically ill, and patients requiring intensive nursing care. The building has radiant hot-water floor heating, and a 9000-square-feet solarium in the center of its U-shaped design.

Pennsylvania

Philadelphia—Hahnemann Medical College and Hospital has announced a $15 million construction program. The first phase of the plan includes construction of a clinical research building at a cost of $1.7 million, a surgical pavilion at a cost of $400,000 and a new nurses' residence and classroom building at a cost of $1.5 million. The construction program will eventually permit the razing of most old buildings. Included in the future construction plans are a medical college building, a resident and intern residence, and an outpatient clinic.

Personnel Changes

(Continued from page 114)

in education and a master's degree in psychology.

● **Harold V. King** has been appointed administrator of Columbia View Manor, a newly incorporated retirement and rehabilitation center, Vancouver, Wash. He was formerly assistant administrator of Salem Memorial Hospital, Salem, Ore. Mr. King is a graduate of the Oklahoma Baptist University, Shawnee, and has an M.S. degree from Northwestern University, Chicago.

● **Harold G. Koach** has been appointed administrator of Wyckoff Heights Hospital, Brooklyn. He was formerly assistant administrator and then for more than six years administrator of Binghamton (N.Y.) City Hospital. He holds a master's degree in hospital administration from Columbia University. Mr. Koach is presently serving as president of the Central New York Regional Hospital Council and as member of the boards of directors of Broome County Mental Health Association, Group Hospital Service Inc. (Blue Cross), and Broome County Social Planning Council.

● **Thomas A. Larkin, R.N.,** has been appointed administrator of Wilmington (Del.) General Hospital. He was formerly administrator of Children's Hospital, Baltimore. Mr. Larkin holds a master's degree in hospital administration from Columbia University. He is chairman of the council of public education of the Maryland-District of Columbia-Delaware Hospital Association.

Mr. Larkin succeeds **Leo G. Schmel-**

zer, who had been administrative director of Wilmington General Hospital since 1955. Mr. Schmelzer began his administrative career in 1924 at the State of Wisconsin General Hospital and Student Infirmary, Madison, Wis. In 1933 he became assistant administrator of this institution as well as of the Wisconsin Orthopedic Hospital for Children. He was later superintendent of the George Washington University Hospital and then administrator of Garfield Memorial Hospital (now part of Washington Hospital Center), Washington, D.C.

● **Harold W. Maysent** (see Paul E. Bourquin item).

● **Robert W. McCuistion** has been appointed administrator of Forrest Memorial Hospital, Forrest City, Ark., succeeding **Joe B. Carmical,** who resigned to accept the position of administrator at Bradley County Memorial Hospital, Warren, Ark. Mr. McCuistion practiced law and was business manager of St. Mary's Hospital, Dermott, Ark., until 1957, when he was named administrator of Stuttgart (Ark.) Memorial Hospital. He is president of Arkansas Hospital Administrators' Forum, past president of the Arkansas chapter of the American Association of Hospital Accountants and treasurer of the Arkansas Hospital Association.

● **Raymond L. Pelton,** assistant administrator of Hinsdale (Ill.) Sanitarium and Hospital, has been named administrator of White Memorial Hospital and Clinic, Los Angeles. He succeeds **Erwin J. Remboldt,** who became administrator of Glendale (Calif.) Sanitarium and Hospital. Mr. Pelton is a graduate of Union College, Lincoln, Nebr., and has a master's degree in hospital administration from Northwestern University.

● **Roy R. Prangley** has been appointed administrator of Norfolk (Va.) General Hospital. For the past 14 years he has been administrator of St. Luke's Hospital, Denver. Mr. Prangley is a past president of the Colorado Hospital Association, and received his college education at the University of Colorado.

● **Erwin J. Remboldt** (see Raymond L. Pelton item).

● **Ralph H. Ross** (see Robert G. Taplin item).

● **Harold M. Salkind** has been appointed administrator of Boulevard Hospital, Long Island City, N.Y. He was formerly administrator of Trafalgar Hospital, New York City.

● **Andrew W. Saphiloff** has been appointed administrator of Parkview Memorial Hospital, Arlington, Calif. He was formerly administrative services director, General State Hospital, Petersburg, Va. Mr. Saphiloff is a graduate of the Northwestern University program in hospital administration.

● **Leo G. Schmelzer** (see T. A. Larkin item).

● **Harold A. Schneider** has been appointed assistant director of Jewish Memorial Hospital, New York City. He was formerly assistant director of Maimonides Hospital, Brooklyn.

● **Howard J. Semingson** has been appointed administrator of Trinity Hospital, Minot, N.D. He was for-

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merly acting administrator for six months, and prior to that was assistant administrator at North Dakota State Hospital, Jamestown.

● **James F. Shepherd** has been appointed administrator of Putnam County Hospital, Greencastle, Ind. He was formerly administrative assistant at Flower Hospital, Toledo, Ohio.

Mr. Shepherd is a graduate of the Northwestern University program in hospital administration.

● **Sister Angela Clare, CCVI,** has been named administrator of Spohn Hospital, Corpus Christi, Tex., succeeding **Sister Mary Eustace, CCVI,** who became associate administrator of Santa Rosa Hospital, San Antonio. Sister Clare holds a master's degree in hospital administration from St. Louis University.

● **Sister Helen Margaret, O.P.,** has been appointed administrator of Rose de Lima Hospital, Henderson, Nev. She was formerly associate professor of nursing and director of the collegiate program of nursing at Barry College, Miami, Fla.

● **Sister M. Igmara, O.P.** (see Sister M. Pretiosa, item).

● **Sister M. Patricia Glynn, S.F.P.,** has been appointed administrator of St. Francis Hospital, Jersey City, N.J., succeeding **Sister M. Bonavita McCarthy.** Sister M. Patricia was formerly administrator at St. Francis Hospital, Bronx, N.Y. (1953-1959) and at St. Michael's Hospital, Newark, N.J. (1947-1953). Sister M. Bonavita has succeeded Sister M. Patricia at the Bronx hospital.

● **Sister M. Pretiosa, O.P., R.N.,** has been appointed administrator of Mount Carmel Hospital, Colville, Wash., succeeding **Sister M. Igmara, O.P.,** who was transferred to St. Martin's Hospital, Tonasket, Wash. Sister M. Pretiosa was formerly administrator of St. Joseph's Hospital, Chewelah, Wash.

● **Arthur W. Smith, F.A.C.H.A.,** has been appointed executive director of Presbyterian Home-Hospital and Westminster Place, Evanston, Ill. Westminster Place, an expansion project of the hospital, will be a self-supporting community of retirement homes and apartments, designed for independent living for the aged. Mr. Smith was formerly director of Macon (Ga.) Hospital.

● **Robert Snyder** has been promoted to assistant to the administrator of Hahnemann Medical College and Hospital, Philadelphia. He was formerly personnel director at that hospital. Mr. Snyder holds a B.S. degree from Villanova University, Villanova, Pa.

● **John H. Stocking** has been appointed assistant executive director of Midway Hospital and Mounds Park Hospital, St. Paul, Minn., both sponsored by Baptist Hospital Fund, Inc. Mr. Stocking was formerly administrative assistant at Northwestern Hospital, Minneapolis. He is a graduate of the Northwestern University program in hospital administration.

● **John L. Sundberg** has been appointed administrator of Pacoima (Calif.) Memorial Lutheran Hospital. He was formerly administrator of Crenshaw Hospital, Los Angeles. Mr. Sundberg's first position as administrator was with The Dalles (Ore.) General Hospital. He had also been administrator of Caldwell (Idaho) Memorial Hospital. Mr. Sundberg had served as vice president and president-elect of the Oregon Association of Hospitals and later as president of the Idaho Hospital Association. He has also been active in state, regional and national hospital associations in other capacities.

● **Robert G. Taplin** has been appointed administrator of Brightlook Hospital, St. Johnsbury, Vt. He succeeds **Ralph H. Ross** who continues as president of the hospital and who is the current president of the Vermont Hospital Association.

● **William D. Thompson** has been appointed administrator of Underwood Hospital, Woodbury, N.J., succeeding **Geoffrey B. Torney,** who resigned to become the administrator of Knox County General Hospital, Rockland, Maine. Mr. Thompson was formerly assistant administrator of Salem (N.J.) County Memorial Hospital. He holds a master's degree in hospital administration from Columbia University.

● **Robert Trimble** has been appointed administrator of Ardmore (Okla.) Sanitarium and Hospital, succeeding **Kent Griffin** who has been transferred to the Florida Sanitarium and Hospital, Orlando, as assistant administrator, a position held by Mr. Trimble until he came to Ardmore. Mr. Trimble also had another administrative position in Orlando, at Dr. P. Phillips Memorial Hospital.

● **John C. VanMetre** has been appointed administrator of Doctors General Hospital, Rogers Park, Ill. He was formerly administrator of Portsmouth (N.H.) Hospital, Northern Indiana Children's Hospital, South Bend, and Children's Hospital of Toledo (Ohio). He is a fellow of the American College of Hospital Administrators.

● **John M. Vickrey** has been appointed manager of the Veterans Administration Center, Whipple, Ariz., having resigned as special assistant to the manager of the Salt Lake City VA hospital. Mr. Vickrey began his service with the VA at its Albuquerque, N.M., hospital, and for a time was an administrative officer and then management analyst at the VA central office in Washington, D.C.

● **Harold Von Gunden** has been appointed assistant administrator and controller of Clearfield (Pa.) Hospital. His former position with that hospital was only that of controller.

Deaths

Frank E. Boston, M.D., founder of Elm Terrace Hospital (now North Penn Hospital), Lansdale, Pa., died February 8, at the age of 69, after a long illness.

Lt. Col. Francis Cusick Nelson, MSC, a veteran information officer in the Army Service, died February 14 of a heart attack at the age of 44. Colonel Nelson recently received a certificate of achievement for his outstanding service from 1956 to 1959 as executive officer of the U.S. Army Hospital, Ft. Leavenworth, Kans. Colonel Nelson held a master's degree in hospital administration from Baylor University, Waco, Tex.

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ACCOUNTING RECORD AND REPORT FORMS: These forms are based on the accounting plan of the American Hospital Association as set out in this handbook on hospital accounting. Write for samples and prices from The Steck Company, Box 16, Austin 61, Texas.

PURCHASING FORMS: A complete line of purchase orders, quotation requests, requisition for purchase order, purchase record, price inquiry, and other purchasing forms. Write for samples and prices from The Steck Company, Box 16, Austin 61, Texas.

POSITIONS OPEN

ASSOCIATE DIRECTOR OF NURSING: 416 bed—65 bassinet general hospital. All services. School of Nursing, Intern and Resident Program. Masters degree preferred. Salary open, based on preparation and experience. Expenses paid for personal interview. Forward detailed resume of training and experience to Mrs. Phyllis Loucks, Director of Nursing, Butterworth Hospital, Grand Rapids 3, Michigan.

NURSE ANESTHETISTS: to complete staff of three for 85-adult bed hospital. Situated midway on Pennsylvania Turnpike between Pittsburgh and Harrisburg. Famous Resort Area. Salary open, liberal personnel policies—Apply Miss M. Valigorsky, C.R.N.A., Memorial Hospital of Bedford County or telephone Collect—Bedford 655.

REGISTERED NURSES: 90 bed Accredited Hospital. Top salary. Excellent benefits, good personnel policies, opportunities for promotion. Apply: Administrator, Sidney A. Sumby Hospital, 234 Visger Road, River Rouge 18, Michigan.

DIETITIAN, THERAPEUTIC: ADA member, for 400 bed hospital in Chicago suburb. Completely new, ultra-modern Food Service Department. Salary open. Apply Personnel Department, St. Francis Hospital, Evanston, Illinois.

CHIEF DIETITIAN: 245 bed—general accredited hospital, featuring ultra modern kitchen—Mealpack equipment. Progressive policies. Excellent Salary. Write James G. Carr, Jr., Administrator, Memorial Hospital, Casper, Wyoming.

DIETITIAN: Vacancy at a Central Hospital within a chain of ten general hospitals with active APC's operated in coal mining region of eastern Kentucky, southwestern Virginia and southern West Virginia. ADA membership is required with experience in teaching and/or therapeutics. Food Clinic experience desirable. Salary at the rate of $4,960 per annum; 40 hour week; 4 weeks paid vacation; 7 paid holidays; laundry of uniforms. Social Security. Call or write: The MINERS MEMORIAL HOSPITAL ASSOCIATION, Box 61, 110 Logan Street, Williamson, West Virginia. Phone: BELmont 5-2424.

REGISTERED MEDICAL RECORD LIBRARIANS: Positions in two of ten general hospitals located in eastern Kentucky, southwestern Virginia, and southern West Virginia, operating on a regional pattern. One position can be filled by a recent graduate, other position requires 5 years experience for consultative duty to community hospitals in region. Salary $4440 and $4860 per annum. 40 hour week. 7 paid holidays, 4 weeks vacation, Social Security, employee health and increment program. WRITE: Miners Memorial Hospital Association, Box 61, Williamson, West Virginia.

DIRECTOR OF NURSING SERVICE at La Crosse Lutheran Hospital. 250 bed. Excellent salary and other benefits. Degree in nursing service desired. Apply to Stanley L. Sims, Administrator, 1910 South Avenue. La Crosse, Wisconsin.

BACTERIOLOGIST: Laboratory Technician; ASCP preferred; Bacteriology experience essential; good salary; new laboratory. Apply to W. S. Leedale, Personnel Officer, Lake County Memorial Hospital, Painesville, Ohio.

DIRECTOR OF NURSES: 130 bed general hospital with nursing staff of approximately 110. Requirements are: Age: 35 to 50, Experience: Degree preferable and at least 4 years experience as Director of Nurses in a general hospital. Salary: Open. Position open: April 18 or before. Contact Administrator, Kaiser Foundation Hospital, 9961 Sierra Avenue, Fontana, California.

PUBLIC RELATIONS. Director wanted. 150 bed accredited community hospital, expansion immediately to 250 beds. Needs someone with ability to speak, write, and enjoy contact with public. Experience desirable but not essential. Salary open. Send resume. Administrator, Norwood Hospital, Norwood, Mass.

DIETITIAN: ADA member, Therapeutic or Administrative, for 225 bed hospital in western suburb 16 miles west of Chicago's loop. Well equipped Dietary Department. Regular hours. 1 month vacation and other liberal benefits. Salary commensurate with ability. Apply Miss M. L. Schoeneich, Chief Dietitian, Memorial Hospital, Elmhurst, Illinois.

NURSE ANESTHETISTS: for 220 bed community hospital. Working with private group. Two full time M.D.'s, four Nurses, all Agents & Techniques. Modernization program going on. Two and one-half hours from Boston & New York. Write G. J. Carroll, M.D. William W. Backus Hospital, Norwich, Connecticut.

ASSISTANT MEDICAL RECORD LIBRARIAN: 670 bed general hospital with large Out Patient Service. I.B.M., Terminal Digit and Soundex Procedures. Opportunity to supervise large staff. Liberal personnel policies. Apply Personnel Director, Harper Hospital, Detroit, Michigan.

NURSING SUPERVISOR at Algoma Memorial Hospital. Forty-six beds. Salary dependent upon qualifications and experience. Degree not necessary. Apply to Walter Hendricks, Administrator, 1510 Fremont Street, Algoma, Wisconsin. Telephone Hunter 7-5511.

NURSE ANESTHETIST: for 200-bed fully accredited general hospital in Baltimore—expansion program now going on—attractive salary arrangements. Liberal fringe benefits of holiday, sick leave, and vacation. Address HOSPITALS, Box J-70.

RESIDENT DOCTOR: needed immediately to cover surgical, medical and pediatric patients. Salary range from $400 to $500 per month depending on qualifications and living requirements. Contact Administrator, St. Luke's Hospital, 2517 Robinwood Avenue, Toledo 10, Ohio.

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DIETITIAN—THERAPEUTIC: new 516-bed approved cancer research hospital, $4668.00 to start for 40-hour week and liberal fringe benefits; apply to: Personnel Director, Roswell Park Memorial Institute, 666 Elm Street, Buffalo, New York.

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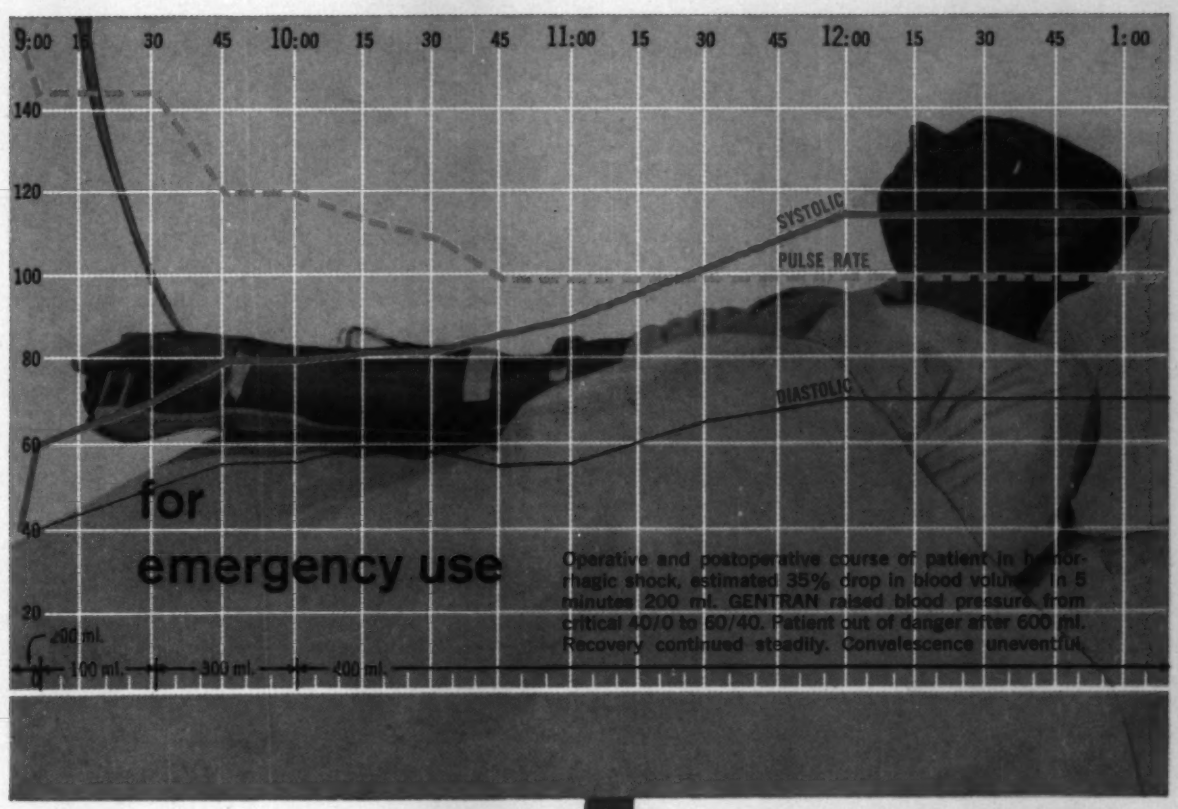

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